



मानव संसाधन प्रभाग, प्रधान कार्यालय,
प्लॉट सं 4, सेक्टर 10, द्वारका, नयी दिल्ली
HUMAN RESOURCES DIVISION HEAD OFFICE,
PLOT No. 4, SECTOR 10, DWARKA, NEW DELHI

TO ALL BRANCHES/OFFICES.

15.12.2022

NOTICE

INDIAN BANKS ASSOCIATION (IBAs) GROUP MEDICAL INSURANCE POLICY FOR RETIRED EMPLOYEES – POLICY DOCUMENT & SOP OF TPA FOR THE POLICY PERIOD 2022-23

The Indian Banks Association (IBA) Group Medical Insurance Policy of retired employees has been renewed from 01.11.2022 to 31.10.2023 through National Insurance Company Ltd. All cashless and reimbursement claims will be serviced by Heritage Health Insurance TPA Pvt. Ltd. (HHI).

Vide our Notice dated 01.11.2022, we have informed detailed Escalation/ contact matrix of Heritage Health Insurance TPA along with list of Pan India network hospitals and claim form. We have now received all the three IBA Group Mediclaim Policy document of retiree policy from National Insurance Company Ltd (NICL).

For the ready reference of retirees, we are enclosing herewith following documents:

A. Policy document

1. IBAs Retiree Without Domiciliary Group Mediclaim Policy 2022-23
2. IBAs Retiree With Domiciliary Group Mediclaim Policy 2022-23
3. IBAs Retiree Group Top up Mediclaim Policy 2022-23

B. SOP of Heritage TPA

1. Cashless Procedure (Annexure I)
2. Reimbursement Procedure (Annexure II)
3. Check list (Annexure III)
4. E-card generation in Website (Annexure IV)
5. Claim detail search in Website (Annexure V)
6. Mobile Application (Annexure VI)

C. List of Circle Wise Contact details



पंजाब नैशुनल बैंक  punjab national bank
...भरोसे का प्रतीक ! ...the name you can BANK upon !

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Further, retirees who desire to obtain a certificate of deduction of premium in IBA's Group Medical Insurance Scheme for retired employees, may obtain the same from Pension Paying branches. All incumbents are advised to issue such certificate to the effect that the premium has been deducted from their accounts after consolidating the amount of premium deducted during the financial year.

All the retirees/ family pensioners may contact their respective Circle Office in case of any issue regarding IBA's Group Medical Policy, further they may raise their grievance as per the Escalation/ contact matrix of the TPA informed earlier.

All are advised to be guided accordingly.

(PARMESH KUMAR)
DEPUTY GENERAL MANAGER

पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000294	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27, Maharashtra GSTIN: 27AAACN9967E1Z3 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल विवरण/ Sales Channel Details कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0 सह दलाल कोड / Co Broker Code: कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

ग्राहक का नाम /Customer Name: PUNJAB NATIONAL BANK - RETIREEES	ग्राहक आईडी /Customer ID: 9701926962	पैन /PAN: AAACP0165G
पता/ Address: SECTOR 10, PLOT NO. 4 DWARKA, City: SOUTH WEST DELHI - DISTRICT OT, District: SOUTH WEST DELHI, State: DELHI, PIN: 110075. Cell: 8860911188	फोन /Phone:	ई-मेल /E-Mail:

पॉलिसी: 01/11/2022 के 00:00 से 31/10/2023 को मध्य रात्रि तक प्रभावी /Policy Effective from 00:00 hours, on 01/11/2022 to midnight of 31/10/2023			
प्रीमियम/ Premium	₹ 74,39,80,784.00	कवर नोट संख्या और तिथि/ Cover Note Number and Date	लागू नहीं/NA
CGST	₹ 0.00	प्रस्ताव संख्या और तिथि/Proposal Number and Date	8800221116662892 Dt. 16/11/2022
SGST/UTGST	₹ 0.00		
IGST	₹ 13,39,16,541.00		
कम:जीएसटी टैडीएस / Less:GST_TDS	₹ 0.00	रसीद संख्या और तिथि/Receipt Number and Date	251100812210002618 Dt. 31/10/2022
पुनर्प्राप्ति योग्य स्टाम्प ड्यूटी /Recoverable Stamp Duty	₹ 0.00	पछिली पॉलिसी संख्या और समाप्ति तिथि/ Previous Policy Number and Expiry Date	251100502110000296 and Dt.31/10/2022
कुल /Total Amount	₹ 87,78,97,325.00	(Rupees Eighty Seven Crore Seventy Eight Lakh Ninety Seven Thousand Three Hundred Twenty Five Only.) Co- Insurance Details: NIC 75.00%,NIA - MUMBAI - 120400 15.00%,OIC - Mumbai Division 7 10.00%.	

Total Location Sum Insured	₹ 6,60,76,00,000.00
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LocationAddress:
1)NEW DELHI,,New Delhi - District Others,New Delhi,Delhi,110098.

Number of families:20868 Number of Lives covered: 37856

SL. No	Coverage	Coverage Description	Sum Insured
1	Standard Cover	GMT WITHOUT DOMICILIARY	6,60,76,00,000.00
	अधिक/Excess:		
	Additional Information: NA		

TPA Details: HERITAGE HEALTH TPA PVT LTD - MUMBAI MBRO I, Champion Building, Ground Floor, 15 Parsi Panchayat Road, Andheri East, Mumbai
400069 - 400069 Contact No : 22 - 28232503 Fax : 022 - 66716299 Email : heritagemumtpa@bajoria.in.

Clauses	As per Annexure I
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टिप्पणियां/ Remarks: 1. Family Definition :Retired/Resigned Employee + Spouse only. OR Widow/Widower
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पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000294	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27 , Maharashtra GSTIN: 27AACN9967E1Z3 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल विवरण/ Sales Channel Details कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0
	सह दलाल कोड / Co Broker Code: कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

2. Separate rates were given for Single person i.e., either of the below mentioned cases :-

- a) Retiree without Spouse
b) Surviving Spouse (Family Pensioner)
(* If employee and spouse both are alive, family floater premium have to be paid.)

3. Sum Insured for Group Health Insurance on Family Floater basis: 1 lac/2lacs/3lacs/4 lacs

4. Data: As per annexure attached

5. Room Rent:

For Sum Insured 1 lacs and 2 Lacs: Room Rent per day shall be payable up to 1.5% of Sum Insured and ICU charges per day shall be payable up to 2% of Sum Insured.

For Sum Insured 3 lacs and 4 lacs: Room rent per day shall be payable up to Rs.5000/- and ICU charges upto Rs.7500/-

6. For critical illness, Hospitalization medical expenses alone is payable. No lump sum fixed benefit is payable.

7. No expenses related to domiciliary treatment shall be covered.

8. No expenses related to maternity is payable. No day one cover available for new born child.

9. No corporate buffer is available.

10. Only employee & spouse are covered. Dependents are excluded from the scope of the policy.

11. After commencement of the policy if any retiree who opts out of the scheme cannot re-join the scheme.

जसिकी गवाही में दनि/ माह /वर्ष को उपरोक्त उल्लेखित कार्यालय पते पर अधोहस्ताक्षरी को वधिवित अधकृत किया जा रहा है उसके हाथ नर्धारित किए जाएं। यह अनुसूची, संलग्न पॉलिसी, खण्ड, पृष्ठांकन और पॉलिसी शर्तों, जो कंपनी वेबसाईट <https://nationalinsurance.nic.co.in> पर उपलब्ध है, को एक अनुबंध के रूप में एक साथ पढ़ा जाए तथा कोई भी शब्द या अभिव्यक्ति जिसके लिए यह विशिष्ट अर्थ पॉलिसी या अनुसूची के किसी भी हिस्से में संलग्न किया गया हो, एक ही अर्थ वहन करेगा चाहे जहाँ भी उल्लेखित हो। यह आश्वासन दिया जाता है कि प्रीमियम चेक के अस्वीकृत के मामले में, यह दस्तावेज स्वतः प्राथमिकता नरिस्त हो जाएगी। **IN WITNESS WHEREOF, the undersigned being duly authorized hereunto set his/ her hand at the office address mentioned above, this 16/November/2022. This schedule, the attached policy, the clauses, the endorsements and policy wordings as available in the website <https://nationalinsurance.nic.co.in> shall be read together as one contract and any word or expression to which the specific meaning has been attached in any part of this policy or of the schedule shall bear the same meaning wherever it may appear. It is warranted that IN CASE OF DISHONOUR OF THE PREMIUM CHEQUE, THIS DOCUMENT STANDS AUTOMATICALLY CANCELLED 'AB-INITIO'**

इंश्योरेंस इंडियल मिटिड

स्टॉप इयुलिमिटेड
Stamp
Duty:
(₹ 1.00)

कृत नेशनल इन्श्योरेंस कंपनी
For and on behalf of National Insurance
Company Limited
अधिकृत हस्ताक्षरकर्ता Authorized
Signatory

TAX INVOICE

Trusted Since 1906

Invoice Serial No: 30154H2C00000294

Invoice Date: 16/11/2022

Details of Supplier:

National Insurance Company Limited.,
MUMBAI DIVISION XI IInd Floor, National Insurance Building,,14, Jamshedji Tata Road,,Churchgate - 400020
State : 27, Maharashtra
GSTIN No : 27AAACN9967E1Z3

Details Of Receiver : PUNJAB NATIONAL BANK - RETIREES

Address : SECTOR 10, PLOT NO. 4 DWARKA
City : SOUTH WEST DELHI - DISTRICT OT,
District: SOUTH WEST DELHI,
State: DELHI,
PIN: 110075.

Place Of Supply State : Delhi
State Code : 7
GSTIN No : 07AAACP0165G1ZR

सैक कोड/ SAC Code	सेवा का विवरण/ Description of Service	कुल/Total(₹)	छूट/ Discount	टैक्स योग्य/ मूल्य/Taxable Value(₹)	सीजीएसटी को राशि/ CGST		एसजीएसटी/यूटीजीएसटी/ SGST/UTGST		आईजीएसटी/IGST		केरला बाढ़ उपकर/Kerala Flood Cess
					दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	राशि/Amount(₹)
997139	Other non-life insurance services (excluding reinsurance services)	74,39,80,784	0%	74,39,80,784	0%	0	0%	0	18%	13,39,16,541	0
TOTAL		74,39,80,784		74,39,80,784		0		0		13,39,16,541	0

कुल इनवॉयस मूल्य (अंकों में) Total Invoice Value (In figures) :
₹ 87,78,97,325

कुल इनवॉयस मूल्य (शब्दों में) Total Invoice Value (In words) : रूपए/Rupees
Eighty Seven Crore Seventy Eight Lakh Ninety Seven Thousand Three Hundred Twenty Five
केवल/Only.

रिवर्स चार्ज के अधीन टैक्स की राशि Amount of Tax Subject to Reverse Charge : No

E.&O.E

कृते नेशनल इन्श्योरन्स कंपनी लिमिटेड/ For
and on behalf of National Insurance Company Limited



अधिकृत हस्ताक्षरकर्ता/ Authorized Signatory



Part – II

1 RECITAL CLAUSE

1.1 Whereas the Proposer designated in the Schedule hereto has by a proposal together with declaration, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1.2 OPERATIVE CLAUSE

The Company undertakes that if during the Policy Period stated in the Schedule, any Insured Person(s) shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury), requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sublimits contained herein as well as shown in the Table of Benefits, and shall not exceed the Sum Insured of the Insured Person as mentioned in the Schedule.

1.3 BASIC COVER:

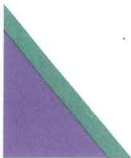
1.3.1 In the event of any claim becoming admissible under this scheme, the company will pay to the Hospital/Nursing Home or Insured Person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of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

A) Room and boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the Schedule or the actual amount whichever is less.

B) Intensive care Unit (ICU) expenses not exceeding per day limit as mentioned in the Schedule or actual amount whichever is less.

C) Surgeon, team of surgeons, Assistant surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists Fees.

D) Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO Charges, Aesthetic, Oxygen, Blood, Operation Theatre Charges, surgical appliances, OT Consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator,



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Orthopaedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve replacements, vascular stents, any other valve replacement, Laboratory/Diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.

E) Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.3.2 Pre-Hospitalization and Post- Hospitalization Expenses – Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period up to 30 days prior to hospitalization and during the period up to 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalization claim is admissible under the policy.

2. Definitions:

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

2.2 ALTERNATIVE TREATMENTS-Alternative treatments are forms of treatment other than treatment "Allopathic" or "Modern medicine" and includes Ayurveda, Unani, Siddha, Naturopathy and Homeopathy in the Indian context.

2.3 ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment has been taken.

2.4 CANCELLATION defines the terms on which the policy contract can be terminated either by the insurer or the insured person by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payment of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre – authorization approved.

2.6 CONGENITAL ANOMALY refers to a condition(s) which is present since birth and which is abnormal with reference to form, structure or position.

1 Internal Congenital Anomaly

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

2 External Congenital Anomaly

Which is in the visible and accessible parts of the body.

2.7 CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

2.8 CONTINUOUS COVERAGE means uninterrupted coverage of the insured person under our



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Individual Health Insurance Policies or Family Floater policy from the time the coverage inception under the policy, provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest sum insured would be reckoned for determining continuous coverage.

However, the benefit of Continuous Coverage getting carried over from other policies will not be available for HIV/AIDS coverage.

2.9 DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical set – up 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:

- a. Has qualified nursing staff under its employment.
- b. Has qualified Medical practitioner(s) in charge
- c. Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

2.10 DAY CARE TREATMENT-Day Care Treatment means the medical treatment and / or surgical procedure which is-

- i) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and
- ii) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.11 DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DISCLOSURE TO INFORMATION NORM: 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.

2.14 EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

2.15 EMERGENCY DENTAL TREATMENT means the services or supplies provided by a Licensed dentist, Hospital or other provider that are medically and immediately necessary to treat dental

problems resulting from injury. However, this definition shall not include any treatment taken for a pre-existing condition.

2.16 EMERGENCY MEDICAL TREATMENT means the services or supplies provided by a Physician, Hospital or Licensed provider that are medically necessary to treat any illness or other covered condition that is acute (onset is sudden and unexpected), considered life threatening and one which if left untreated, could deteriorate resulting in serious and irreparable harm.

2.17 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.

2.18 HOSPITAL/NURSING HOME 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 a 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.

For Ayurveda, Unani, Siddha, Naturopathy and Homeopathy treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.2 below.

2.19 HOSPITALISATION

Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive "In-patient care" hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

For the list of these specified day care procedures/treatments, please see 3.3.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.

2.20 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in net work provider.



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2.21 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.

(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:

- It needs ongoing or long term monitoring through consultations, examinations, check- ups, and/or tests.
- It needs ongoing or long term control or relief of symptoms.
- It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
- It continues indefinitely.
- It recurs or is likely to recur.

2.22 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.

2.23 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.

2.24 INSURED PERSON means the employee of the bank and each of the other family members who are covered under this policy as shown in the Schedule.

2.25 INTENSIVE CARE UNIT means an identified 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.

2.26 INTENSIVE CARE (ICU) CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.27 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.28 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.

2.29 MEDICALLY NECESSARY TREATMENT is defined as any treatment, tests, 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 by 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 conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.30 MEDICAL PRACTITIONER: A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian medicine or for Homeopathy set up by the Government of India or a State Government and is there by entitled to practice medicine within its jurisdiction, and is acting within the scope and jurisdiction of license.

The term Medical Practitioner would include Physician, Specialist and Surgeon. The registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

2.31 NETWORK PROVIDER means the hospital/nursing home 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.

PPN-PREFERRED PROVIDER NETWORK means a network of hospitals which have agreed to a cashless packaged pricing for specified planned procedures for the insured person. Updated list of network provider/PPN is available on website of the company (https://nationalinsurance.co.in/tpa_ppn_network_hospital) and website of the TPA mentioned in the schedule and is subject to amendment from time to time.

2.32 NON-NETWORKHOSPITALS means any hospital, day care centre or other provider that is not part of the network.

2.33 NOTIFICATION OF CLAIM is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognized modes of communication.

2.34 OPD (Out-patient) TREATMENT means the 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 a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2.35 PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Schedule.

2.36 PORTABILITY means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

2.37 PRE-EXISTING DISEASE means any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or was diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from pre-existing disease shall be considered as a part of the pre-existing disease.

2.38 PRE-HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that

- Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and
- The In-patient Hospitalization claim for such Hospitalization is admissible by us.

2.40 POST HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 90 days after the insured person is discharged from the hospital provided that:

- Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.41 PSYCHIATRIC DISORDER means clinically significant Psychological or behavioral syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behavior or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the insured person in respect of whom a claim is lodged.

2.42 PSYCHOSOMATIC DISORDER means one or more psychological or behavioral problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the insured person in respect of

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whom a claim is lodged.

2.43 QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

2.44 REASONABLE AND CUSTOMARY CHARGES

Reasonable and Customary charges mean 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 illness/injury involved.

2.45 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.

2.46 ROOM RENT shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

2.47 SUM INSURED is the maximum amount of coverage under this policy opted for all insured persons shown in the schedule.

2.48 SURGERY OR SURGICAL PROCEDURE means manual and /or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.49 THIRD PARTY ADMINISTRATOR (TPA) means any person who is registered under the IRDAI (Third Party Administrators-Health Services) Regulations 2016 notified by the Authority, and is engaged for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those.

2.50 UNPROVEN/EXPERIMENTAL TREATMENT means any treatment including drug experimental therapy which is not based on established medical practice in India.

2.51 WE/OUR/US/COMPANY means NATIONAL INSURANCE COMPANY LIMITED

3 ADDITIONAL COVERAGES:

3.1 Domiciliary Hospitalisation means medical treatment for a period exceeding 3 days for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- A) The condition of the patient is such that he/she is not in a condition to be removed to a hospital or
- B) The patient takes treatment at home on account of non-availability of room in hospital.

3.2 Alternative Treatment- Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

- Central or State Government AYUSH Hospital; or
- Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:

- Having at least 5 in-patient beds;
- Having qualified AYUSH *Medical Practitioner* in charge round the clock;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

3.3 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	21	Haemo dialysis
2	Appendectomy	22	Fissurectomy/Fistulectomy
3	Ascitic/Pleural tapping	23	Mastoidectomy
4	Auroplasty not Cosmetic in nature	24	Hydrocele Surgeries
5	Coronary/Renal Angiography	25	Hysterectomy
6	Coronary angioplasty	26	Inguinal/ventral/mbilical/femoral hernia surgeries
7	Dental Surgery	27	Parental Chemotherapy
8	D&C	28	Polypectomy
9	Excision of cyst/granuloma/lump/tumor	29	Septoplasty
10	Eye Surgery	30	Piles/Fistula Surgeries
11	Fracture including hairline fracture/dislocation	31	Prostate surgeries
12	Radiotherapy	32	Sinusitis surgeries
13	Chemotherapy	33	Tonsillectomy
14	Lithotripsy	34	Liver aspiration
15	Incision and drainage of abscess	35	Sclerotherapy
16	Varicoselectomy	36	Varicose Vein Ligation
17	Wound Suturing	37	All scopes along with biopsies
18	FESS	38	Lumbar puncture



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19	Operations/Micro Surgical operations on the nose, mouth, middle ear/internal ear, tongue, face, tonsils & adenoids, salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.	39	Treatment for Age related Macular Degeneration (ARMD) and Intra Vitreal injections for eye disorders other than ARMD also.
20	Approved targeted therapies for treatment of Cancer in day care and on standalone basis. (Immunotherapy – Monoclonal Antibody Cancer treatment on standalone basis).	-	----

This condition will also apply in case of stay in hospital of less than a day provided –

- The treatment is undertaken under General or Local Anesthesia in a hospital/day care Centre in less than a day because of technological advancement and
- Which would have otherwise required hospitalisation of more than a day

3.4 AMBULANCE CHARGES

Ambulance charges are payable up to Rs. 2500 per trip to hospital and/or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs. 750 per hospitalisation.

Ambulance charges actually incurred on transfer from one centre to another centre due to non-availability to medical service/medical complication shall be payable in full.

3.5 PRE EXISTING DISEASES/AILMENTS

Pre-existing diseases are covered under the scheme from day one.

3.6 CONGENITAL ANOMALIES

Expenses for treatment of congenital internal/external diseases, defects anomalies are covered under the policy

3.7 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without hospitalisation up to the sum insured.

3.8 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority eg. Laser surgery, stem cell therapy for treatment of a disease is payable on hospitalisation/day care surgery.

3.9 Treatments taken for accidents can be payable even on OPD basis in a hospital upto Sum Insured

3.10 TAXES AND OTHER CHARGES

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All Taxes, Surcharges, Service charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable.

Charges for diapers and sanitary pads are payable if necessary as part of treatment. Charges for hiring a nurse/attendant during hospitalisation will be payable only in case of recommendation from treating doctor in case ICU/CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.11 Treatment for Genetic disorder and stem cell therapy is covered under the scheme.

3.12 Treatment for Age related Muscular Degeneration (ARMD), treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP) and related treatments are covered under the scheme. Treatment for all neurological/macular degenerative disorders shall be covered under the scheme.

3.13 Rental charges for external and/or durable medical equipment used for diagnosis and/or treatment including CPAP, CAPD, Bi-PAP, Infusion pump and related equipment will be covered under the scheme. However, purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.14 Ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, braces, stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including glucose test strips) /Nebulizer/prosthetic device/Thermometer, alpha/water bed and similar items will be covered under the scheme.

3.15 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the medical practitioner even if taken at home.

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 and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of:

4.1. Investigation & Evaluation

- Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.2. Rest Cure, Rehabilitation and Respite Care

- Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - Custodial care either at home or in a nursing facility for personal care such as help with activities of

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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.

4.3. Change-of-Gender Treatments

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

4.5. Self-Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.6. Birth control, Sterility and Infertility

Expenses related to sterility and infertility. This includes: i. Any type of sterilization ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI iii. Gestational Surrogacy iv. Reversal of sterilization

4.7. Refractive Error

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

4.8. 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.

4.9. Drug/Alcohol Abuse

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

4.10. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician, Outstation doctor/surgeon/ consultants' fees and similar expenses (as listed in respective Annexure-I).

4.11. Home Visit Charges

Home visit charges during Pre and Post Hospitalisation of doctor, aya, attendant and nurse.

4.12. Breach of Law

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Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.13 Injury/disease directly or indirectly caused by or attributable to war, invasion, Act of Foreign Enemy, War like operations (whether war be declared or not); Nuclear radiation/weapon/materials.

4.14

- 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 is not covered.
- d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.15 Cost of spectacles and contact lenses, hearing aids, other than Intra-Ocular Lenses and Cochlear Implant.

4.16 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.17 Convalescence, rest cure, obesity treatment and its complications including morbid obesity, Venereal disease and use of intoxication drugs/alcohol.

4.18 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 Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome of a similar kind commonly referred to as AIDS.

4.19 Charges incurred at hospital/nursing home primarily for diagnosis x ray or laboratory examinations or other diagnostic studies not consistent with diagnosis and treatment of positive existence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home unless recommended by the attending doctor.

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

4.21 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, barber or beauty devices, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses unless and otherwise necessitated during the course of treatment.

4.22 Critical illness diagnosed before the commencement of the policy are not covered.

4.23 Expenses on purchase of medicine not supported by bills/receipts/cash memos without valid GST No of the issuer of such bills/receipts/cash memos.

4.24 Domiciliary treatment: Any expenses incurred on Domiciliary treatment are not covered.

5. Claims Procedure

A. Claims Administration and Process

It shall be the condition precedent to admission of our Liability under this policy that the terms and conditions of making payment of premium on full or in time in so far as they relate to anything to be done or complied with by you or any Insured Person, are fulfilled including complying with the following in relation to claims ;

1. On the occurrence or discovery of any illness or injury that may give rise to a claim under this policy, the claims procedure set out below shall be followed.
2. The treatment should be taken as per the advice, directions and guidance of the treating medical practitioner. Any failure to follow such advice, directions and guidance will prejudice the claim.
3. The insured person must submit to medical examination by our medical practitioner in case requested by us and at our cost, as often as we consider reasonable and necessary and we/our representatives must be permitted to inspect the medical and hospitalisation records pertaining to the insured person's treatment and to investigate the circumstances pertaining to the claim.
4. We and our representatives must be given all reasonable cooperation in investigating the claim in order to assess our liability and quantum in respect of the claim.

Notification of Claim

Upon the happening of any event which may give rise to any claim under this policy, the insured or insured's representative shall notify the TPA in writing by letter, email, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within prescribed time limit.

Notification of Claim in case of Cashless facility	TPA must be informed:
In the event of planned hospitalisation	At least 72 hours prior to the insured person's admission to network provider/ PPN hospital
In the event of emergency hospitalisation	Within 24 hours of the insured person's admission to network provider/PPN hospital.

Notification of Claim in case of Reimbursement	TPA must be informed:
In the event of planned hospitalisation	Within 48 hours of the insured person's admission to network provider/non network/ PPN hospital
In the event of emergency hospitalisation	Within 48 hours of the insured person's admission to network provider/ non network /PPN hospital.

B. Procedure for cashless claims

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1. Cashless facility for treatment shall be available to insured in network hospitals only.
2. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network providers/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (<https://nationalinsurance.nic.co.in/en/health-insurance/city-wise-list-ppn-hospitals>) and the TPA mentioned in the schedule
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN, produce the ID card issued by the TPA at the hospital helpdesk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to TPA for authorization. Each request for pre authorization must be through duly completed standard pre-authorization format including the following details:
 - i. The health card which the insurer or the associated TPA has issued to the insured person supported with KYC documents;
 - ii. The Policy Number;
 - iii. Name of the Policy/ Number/Employer;
 - iv. Name and address of insured person/Employee/member in respect of whom the request is being made;
 - v. Nature of the illness/injury and the treatment/surgery required;
 - vi. Name and address of the attending Medical Practitioner;
 - vii. Hospital where the treatment/surgery is proposed to be taken;
 - viii. Proposed date of admission;
5. If these details are not provided in full or sufficient or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.
6. When the associated TPA has obtained sufficient details to access the request, the associated TPA will issue the authorisation letter specifying the specified amount, any specific limitation on the claim, applicable deductibles, and non-payable items if applicable, or We may reject the request for pre-authorisation specifying reason for the rejection.
7. The TPA upon getting cashless request form and related medical information from the insured person/network hospital/PPN shall issue pre-authorisation letter to the hospital after verification.
8. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorised treatment, including dates, hospitals and locations match with the details of the actual treatment received. For Hospitalisation where Cashless Facility is pre-authorised by the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.
9. In the event that the cost of hospitalisation exceeds the authorised limits as mentioned in the

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authorisation letter:

- a. The network provider shall request us for an enhancement of authorization limit as described under section 5.B including details of the specific circumstances which have led to the need for increase in the previously authorised limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
- b. We shall accept or decline such request for enhancement of pre-authorised limit for enhancement.

In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the insured person, the network provider shall obtain a fresh authorisation letter from us in accordance with the process described under 5.B above.

10. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.

11. At the time of discharge:

- a. The Network Provider may forward a final request for authorisation for any residual amount to the TPA along with the discharges summary and the detailed bill break up in accordance with the process described at 5.B above.
- b. Upon receipt of the final authorisation letter from TPA, the insured person may be discharged by the Network Provider.

Note: (Applicable to 5 B): Cashless facility for hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider/PPN hospital for Illness or Injury/Accident/Critical Illness as the case may be which are covered under the policy. For all cashless authorisations, the insured person, will in any event be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and/or opted Deductible (Per Claim/Aggregate/Corporate) (if applicable), directly with the hospital.

12. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The insured person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

13. Claims for pre hospitalisation and post hospitalisation will be settled on a reimbursement basis on production of cash receipts.

C. Procedure for reimbursement of claims

In non-network hospitals payment must be made upfront and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/the bank's office authorised to deal with Health Claims within the prescribed time limit.

For all claims for which Cashless Facilities have not been pre-authorised or for which treatment

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has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

- i. The Policy Number;
- ii. Name of the Policy Number/Employer;
- iii. Name and address of Insured person/Employee/member in respect of whom the request is being made;
- iv. Health Card, photo ID, KYC documents;
- v. Nature of illness or injury and the treatment/Surgery taken;
- vi. Name and address of the attending medical practitioner;
- vii. Hospital where treatment/surgery was taken;
- viii. Date of Admission and Date of Discharge;
- ix. Any other information that may be relevant to the Illness/Injury/Hospitalisation;
- x. Duly completed claim form

D. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.

- i. Duly completed claim form
- ii. Photo ID and Age Proof
- iii. Health Card, Policy copy, Photo ID and KYC documents
- iv. Attending medical practitioner's/surgeon's certificate regarding diagnosis/nature of operation performed along with date of diagnosis, investigation test reports etc supported by the prescription from attending medical practitioner
- v. Original discharge card/day care summary/transfer summary
- vi. Original final hospital bill with all original deposit and final payment receipt
- vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery
- viii. All previous consultation papers indicating history and treatment details for current ailment
- ix. All original diagnostic reports (including imaging and laboratory) along with medical practitioner's prescription and bill/invoice with receipt from diagnostic centre.
- x. All original medicine/pharmacy bills along with medical practitioner's prescription;
- xi. MLC / FIR copy- in Accidental case only;
- xii. Copy of death summary and copy of death certificate (in death claims only);
- xiii. Pre and post-operative imaging reports-in Accidental cases only;
- xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original

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documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.C. & 5.D. And claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and per hospitalisation expenses (limited to 30 days)	Within 30 (Thirty) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 30 (thirty) days from completion of post hospitalisation treatment.

Note: Waiver of this condition may be considered in extreme case of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

3. The insured Person shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
4. All the documents submitted to TPA shall be electronically collected by us for settlement and denial of the claims by the appropriate authority.

E. Scrutiny of Claim Documents

- a. The TPA shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/Network Provider as the case may be within 7 working days of submission of documents. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days, The TPA will send a maximum of 3 (three) reminders. We may, at our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.
- c. The Pre-Hospitalization Medical Expenses Cover claim and Post-Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

F. Claim Assessment

Insurer will pay the fixed or indemnity amount as specified in the applicable Base of Optional Cover in accordance with the terms of the Policy.



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Insurer will assess all admissible claims under the Policy in the following progressive order:

- I. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.
- II. Opted Deductible (PreClaim/Aggregate/Corporate), if any, shall be applicable on the amount payable by Us after applying (I), and (ii) above.
- III. Co-Payments if any, shall be applicable on the amount payable by us after applying (i), and (ii).

The Claim amount assessed under Section 5.F (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit.

- a. Sum Insured

G. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 24 (Twenty Four) days offer a settlement of the claim to the insured person.
2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2%(Two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.
5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7(Seven) days from the date of acceptance of the offer.
6. A claim, which is not covered under the policy cover and conditions, can be rejected.

H. Rejection/ Repudiation of Claim

- a. If the company, for any reasons, decides to reject/repudiate –a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) of investigation report (if any), as the case may be. Where a rejection is communicated by the Company, the Insured Person may, is so desired, within 15 days from the date of receipt of the claims decision represent to the Company for reconsideration of the decision.
- b. In case of rejection of claims, it would go through a committee setup of the Bank, Third Party Administrator and National Insurance Co. Ltd. unless rejected by the committee in real time the claim should not be rejected.

Forming Part of IBA Retirees Without Domiciliary Policy for the year 2022-2023

I. Claim Payment Terms

- I. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
- II. All claims will be payable in India and in Indian rupees.
- III. We are not obligated to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice of guidance provided by a Medical Practitioner.
- IV. The Sum insured opted under the Policy shall be reduced by the amount payable/ paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
- V. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.
- VI. For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
- VII. For Reimbursement claims, the payment shall be made to the Insured person. In the unfortunate event of the Insured person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate of indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.
- J. Claims will be managed through the same Office of the Bank from where it is managed at Present. The Third Party Administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

6 CONDITIONS

6.1 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 Proposer. (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)

6.2 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.

6.3 Communication

- i. All communication should be made in writing.
- ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be

communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

iv. The Company or TPA shall communicate to the Proposer/ Insured Person at the address mentioned in the Schedule.

6.4 Physical Examination

Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured Person in the event of any alleged Illness/Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.5 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)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company. 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 Company or to induce the Company 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 Company.

6.6 Territorial Limit

All medical treatment for the purpose of this policy will have to be taken in India only.

6.7 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The company shall endeavour to give notice for renewal. However, the company is not under obligation to give any notice for renewal.



Forming Part of IBA Retirees Without Domiciliary Policy for the year 2022-2023

- ii. Renewal shall not be denied on the ground that the insured person had made acclaim 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. After the end of the policy period, the policy can be renewed within the Grace Period of 30 days to maintain continuity benefits without break in policy. Cover age is not available during the grace period.
- v. No Loading shall apply on renewals based on individual claims experience.

6.8 Guideline for Addition of members:-

Midterm additions are allowed only for employees retired from their service during currency of the policy subject to intimation received within 30 days.

6.9 Cancellation:

- i. 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
- ii. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period of risk	Rate of premium to be charged
Up to 1 month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

6.10 Territorial Jurisdiction

The All disputes or differences under or in relation to the Policy shall be determined by the Indian court and according to Indian law.

6.11 Maintenance of member Records

The Insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the Insured persons and other relevant details as are normally kept in any institution/ Organization. The Insured shall declare to the company any additions in the number of Insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

It is hereby agreed and understood that, this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to member who cease to be part of the group for any reason whatsoever.

6.12 Low Claim Ratio Discount (Bonus)

Low Claim Ratio Discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ration for the entire group Insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken in to account.

Incurred Claim Ratio under the Policy	Discount
Above 70%	Nil
66-70%	2.50%
61-65%	5%
56-60%	10%
51-55%	15%
41-50%	25%
31-40%	35%
21-30%	40%
Not exceeding 20%	50%

6.13 Arbitration

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.

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.

6.14 Disclaimer

If the company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (12) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover

this claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and

National Insurance Company Limited
CIN : U10200WB1906G01001713
IRDA Registration No. 58



Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

shall not thereafter be recoverable hereunder.

6.15 IRDA Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (health Insurance) Regulations 2016 and IRDA (protection of policyholder's interest) Regulations 2017 as amended from time to time.

6.16 Grievance Redressal

In case of any grievance the insured person may contact the company through Website:
<https://nationalinsurance.nic.co.in/> Post: National Insurance Co. Ltd., Toll free:
18003450330

6A Middleton Street, 7th Floor,

CRM Dept., Kolkata - 700 071

E-mail: customer.relations@nic.co.in

Phn : (033) 2283 1742

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 (Office in-Charge) at that location.

For updated details of grievance officer, kindly refer the link: <https://nationalinsurance.nic.co.in/>

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 (Annexure II).

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

6.17 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.

6.18 Withdrawal of Policy

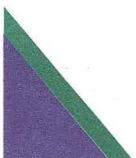
In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy.

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.

1) "Policy Issuing Office: Mumbai"

2) " Consolidated Stamp Duty deposited as per the order of Government of India

For National Insurance Co Ltd



नेशनल इन्श्योरन्स कम्पनी लिमिटेड
National Insurance Company Limited
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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : Incase of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

Annexure I

List I – List of which coverage is not available in the policy	
Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLEY COVER
66	URMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS

5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSE OXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHO BUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE/SPIRIT/ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman		
Gujarat, UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad - 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in		Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27- N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in		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
Madhya Pradesh and Chhattisgarh	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		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
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2396461 / 2396455 Fax: 0674 - 2396429 Email: bimalokpal.bhubaneswar@ecoi.co.in		Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu and Kashmir, UT of 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		Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, SantaCruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
Tamil Nadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	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		Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in		Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in		Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam - a part of the UT of Pondicherry	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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in		
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi - II Bldg., Gr. Floor,		
		Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	
		West Bengal, UT of Andaman and Nicobar Islands, Sikkim	
		Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Bahampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
		Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	
		State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	
		Bihar, Jharkhand.	
		Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	

नेशनल इन्श्योरेंस कम्पनी लिमिटेड
National Insurance Company Limited
CIN : U10200WB1906G01001713
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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
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For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : Incase of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000293	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27, Maharashtra GSTIN: 27AAACN9967E1Z3 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल वविवरण/ Sales Channel Details कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0 सह दलाल कोड / Co Broker Code: कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

ग्राहक का नाम /Customer Name: PUNJAB NATIONAL BANK - RETIRES	ग्राहक आईडी /Customer ID: 9701926962	पैन /PAN: AAACP0165G
पता/ Address: SECTOR 10, PLOT NO. 4 DWARKA, City: SOUTH WEST DELHI - DISTRICT OT, District: SOUTH WEST DELHI, State: DELHI, PIN: 110075. Cell: 8860911188	फोन /Phone: ई-मेल /E-Mail:	

पॉलिसी: 01/11/2022 के 00:00 से 31/10/2023 को मध्य रात्रि तक प्रभावी /Policy Effective from 00:00 hours, on 01/11/2022 to midnight of 31/10/2023			
प्रीमियम/ Premium	₹ 77,17,209.00	कवर नोट संख्या और तथि/ Cover Note Number and Date	लागू नहीं/NA
CGST	₹ 0.00	प्रस्ताव संख्या और तथि/Proposal Number and Date	8800211130958246 Dt. 16/11/2022
SGST/UTGST	₹ 0.00		
IGST	₹ 13,89,098.00		
कम:जीएसटी टैडीएस / Less:GST_TDS	₹ 0.00	रसीद संख्या और तथि/Receipt Number and Date	251100812210002618 Dt. 31/10/2022
पुनर्प्राप्ति योग्य स्टाम्प ड्यूटी /Recoverable Stamp Duty	₹ 0.00	पछिली पॉलिसी संख्या और समाप्ति तथि/ Previous Policy Number and Expiry Date	251100502110000296 and Dt.31/10/2022
कुल /Total Amount	₹ 91,06,307.00		
(Rupees Ninety One Lakh Six Thousand Three Hundred Seven Only.)			
Co- Insurance Details: NIC 75.00%,NIA - MUMBAI - 120400 15.00%,OIC - Mumbai Division 7 10.00%.			

Total Location Sum Insured	₹ 4,13,00,000.00
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LocationAddress:
1)NEW DELHI,,New Delhi - District Others,New Delhi,Delhi,110098.

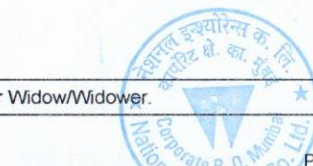
Number of families:143 Number of Lives covered: 236

SL. No	Coverage	Coverage Description	Sum Insured
1	Standard Cover	GMT WITH DOMICILIARY	4,13,00,000.00
	अधिक/Excess:		
	Additional Information: NA		

TPA Details: HERITAGE HEALTH TPA PVT LTD - MUMBAI MBRO I, Champion Building, Ground Floor, 15 Parsi Panchayat Road, Andheri East, Mumbai
400069 - 400069 Contact No : 22 - 28232503 Fax : 022 - 66716299 Email : heritagemumtpa@bajajia.in.

Clauses	As per Annexure I
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टिप्पणियां/ Remarks: 1. Family Definition : Retired/Resigned Employee + Spouse only or Widow/Widower.



पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000293	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27, Maharashtra GSTIN: 27AAACN9967E123 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल विवरण/ <u>Sales Channel Details</u> कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0 सह दलाल कोड / Co Broker Code: कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

2. Separate rates were given for Single person i.e., either of the below mentioned cases :-
a) Retiree without Spouse
b) Surviving Spouse (Family Pensioner)
(* If employee and spouse both are alive, family floater premium have to be paid.)
3. Sum Insured for Group Health Insurance on Family Floater basis: 1 lac/2lacs/3lacs/4 lacs.
4. Data: As per annexure attached.
5. Room Rent:
For Sum Insured 1 lacs and 2 Lacs: Room Rent per day shall be payable up to 1.5% of Sum Insured and ICU charges per day shall be payable up to 2% of Sum Insured.
For Sum Insured 3 lacs and 4 lacs: Room rent per day shall be payable up to Rs.5000/- and ICU charges upto Rs.7500/-
6. For critical illness, Hospitalization medical expenses alone is payable. No lump sum fixed benefit is payable.
7. Domiciliary treatment shall be covered subject to Clause No 3.1 of coverage. The maximum limit of sum insured is 10% of Family floater. The total sum insured is including the domiciliary limit as stated above.
8. No expenses related to maternity is payable. No day one cover available for new born child.
9. No corporate buffer is available.
10. Only employee & spouse are covered. Dependents are excluded from the scope of the policy.
11. After commencement of the policy if any retiree who opts out of the scheme cannot re-join the scheme.

जसिकी गवाही में दनि/ माह /वर्ष को उपरोक्त उल्लेखित कार्यालय पते पर अधोहस्ताक्षरी को वधिवित अधिकृत किया जा रहा है उसके हाथ निर्धारित करि जाएं। यह अनुसूची, संलग्न पॉलिसी, खण्ड, पृष्ठांकन और पॉलिसी शब्दों, जो कंपनी वेबसाइट <https://nationalinsurance.nic.co.in> पर उपलब्ध है, को एक अनुबंध के रुप में एक साथ पढ़ा जाए तथा कोई भी शब्द या अभिव्यक्ति जिसके लिए यह विशिष्ट अर्थ पॉलिसी या अनुसूची के किसी भी हिस्से में संलग्न किया गया हो, एक ही अर्थ वहन करेगा चाहे जहाँ भी उल्लेखित हो। यह आश्वासन दिया जाता है कि प्रीमियम चेक के अस्वीकृत के मामले में, यह दस्तावेज स्वतः प्रथमिकता नरिस्त हो जाएगी। **IN WITNESS WHEREOF, the undersigned being duly authorized hereunto set his/ her hand at the office address mentioned above, this 16/November/2022. This schedule, the attached policy, the clauses, the endorsements and policy wordings as available in the website <https://nationalinsurance.nic.co.in> shall be read together as one contract and any word or expression to which the specific meaning has been attached in any part of this policy or of the schedule shall bear the same meaning wherever it may appear. It is warranted that IN CASE OF DISHONOUR OF THE PREMIUM CHEQUE, THIS DOCUMENT STANDS AUTOMATICALLY CANCELLED 'AB-INITIO'**

इंश्योरेंस इंडिया लिमिटेड

स्टॉप इयुलिमिटेड/ Stamp
Duty:
(₹ 1.00)

कृते नेशनल इन्श्योरेंस कंपनी
For and on behalf of National Insurance
Company Limited
अधिकृत हस्ताक्षरकर्ता/ Authorized
Signatory

TAX INVOICE



Trusted Since 1906

Invoice Serial No: 30154H2C00000293

Invoice Date: 16/11/2022

Details of Supplier:

National Insurance Company Limited.,
MUMBAI DIVISION XI IInd Floor, National Insurance Building,,14, Jamshedji Tata Road,,Churchgate - 400020
State : 27, Maharashtra
GSTIN No : 27AAACN9967E1Z3

Details Of Receiver : PUNJAB NATIONAL BANK - RETIREES

Address : SECTOR 10, PLOT NO. 4 DWARKA
City : SOUTH WEST DELHI - DISTRICT OT,
District: SOUTH WEST DELHI,
State: DELHI,
PIN: 110075.

Place Of Supply State : Delhi
State Code : 7
GSTIN No : 07AAACP0165G1ZR

सैंक कोड/ SAC Code	सेवा का विवरण/ Descripti on of Service	कुल/Total(₹)	छूट/ Discou nt	टैक्स योग्य/ मूल्य/Taxable Value(₹)	सीजीएसटी की राशि/ CGST		एसजीएसटी/यूटीजीएसटी/ SGST/UTGST		आईजीएसटी/IGST		केरला बाढ़ उपकर/Kerala Flood Cess
					दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	राशि/Amount(₹)
997139	Other non-life insurance services (excluding reinsurance services)	77,17,209	0%	77,17,209	0%	0	0%	0	18%	13,89,098	0
TOTAL		77,17,209		77,17,209		0		0		13,89,098	0

कुल इनवॉयस मूल्य (अंकों में) Total Invoice Value (In figures) :
₹ 91,06,307

कुल इनवॉयस मूल्य (शब्दों में) Total Invoice Value (In words) : रूपए/Rupees
Ninety One Lakh Six Thousand Three Hundred Seven
केवल/Only.

रिवर्स चार्ज के अधीन टैक्स की राशि Amount of Tax Subject to Reverse Charge : No

E.&O.E

कृते नेशनल इन्श्योरेंस कंपनी लिमिटेड/ For
and on behalf of National Insurance Company Limited

अधिकृत हस्ताक्षरकर्ता/ Authorized Signatory



Part – II**1 RECITAL CLAUSE**

1.1 Whereas the Proposer designated in the Schedule hereto has by a proposal together with declaration, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (here in after called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons)and has paid the premium as consideration for such insurance.

1.2 OPERATIVE CLAUSE

The Company undertakes that if during the Policy Period stated in the Schedule, any Insured Person(s) shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury), requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Sum Insured of the Insured Person as mentioned in the Schedule.

1.3 BASIC COVER:

1.3.1 In the event of any claim becoming admissible under this scheme, the company will pay 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.

A) Room and boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the Schedule or the actual amount whichever is less.

B) Intensive care Unit (ICU) expenses not exceeding per day limit as mentioned in the Schedule or actual amount whichever is less.

C) Surgeon, team of surgeons, Assistant surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists Fees.

D) Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO Charges, Aesthetic, Oxygen, Blood, Operation Theatre Charges, surgical appliances, OT Consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, Orthopaedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve replacements, vascular stents, any other valve

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड
National Insurance Company Limited
CIN : U10200WB1906G01001713
IRDA Registration No. 58



पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

replacement, Laboratory/Diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.

E) Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.3.2 Pre-Hospitalization and Post- Hospitalization Expenses – Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period up to 30 days prior to hospitalization and during the period up to 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalization claim is admissible under the policy.

2. Definitions:

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

2.2 ALTERNATIVE TREATMENTS- Alternative treatments are forms of treatment other than treatment "Allopathic" or "Modern medicine" and includes Ayurveda, Unani, Siddha, Naturopathy and Homeopathy in the Indian context.

2.3 ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment has been taken.

2.4 CANCELLATION defines the terms on which the policy contract can be terminated either by the insurer or the insured person by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payment of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre – authorization approved.

2.6 CONGENITAL ANOMALY refers to a condition(s) which is present since birth and which is abnormal with reference to form, structure or position.

1 Internal Congenital Anomaly

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

2 External Congenital Anomaly

Which is in the visible and accessible parts of the body.

2.7 CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

2.8 CONTINUOUS COVERAGE means uninterrupted coverage of the insured person under our Individual Health Insurance Policies or Family Floater policy from the time the coverage incepted under the policy, provided a break in the insurance period not exceeding thirty days

being grace period shall not be reckoned as an interruption in coverage for the purposes of this clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest sum insured would be reckoned for determining continuous coverage.

However, the benefit of Continuous Coverage getting carried over from other policies will not be available for HIV/AIDS coverage.

2.9 DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical set – up 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 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 Company's authorized personnel.

2.10 DAY CARE TREATMENT-Day Care Treatment means the medical treatment and / or surgical procedure which is-

- Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.11 DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DISCLOSURE TO INFORMATION NORM: 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.

2.14 EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

2.15 EMERGENCY DENTAL TREATMENT means the services or supplies provided by a Licensed dentist, Hospital or other provider that are medically and immediately necessary to treat dental problems resulting from injury. However, this definition shall not include any treatment taken for a pre-existing condition

2.16 EMERGENCY MEDICAL TREATMENT means the services or supplies provided by a Physician, Hospital or Licensed provider that are medically necessary to treat any illness or other covered condition that is acute (onset is sudden and unexpected), considered life threatening and one which if left untreated, could deteriorate resulting in serious and irreparable harm.

2.17 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.

2.18 HOSPITAL/NURSING HOME 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 a 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. For Ayurveda, Unani, Siddha, Naturopathy and Homeopathy treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.3 below.

2.19 HOSPITALISATION

Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive "In-patient care" hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

For the list of these specified day care procedures/treatments, please see 3.4.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.

2.20 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in network provider.

2.21 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.

(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:

- It needs ongoing or long term monitoring through consultations, examinations, check-ups, and/or tests.
- It needs ongoing or long term control or relief of symptoms.
- It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
- It continues indefinitely.
- It recurs or is likely to recur.

2.22 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.

2.23 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.

2.24 INSURED PERSON means the employee of the bank and each of the other family members who are covered under this policy as shown in the Schedule.

2.25 INTENSIVE CARE UNIT means an identified 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.

2.26 INTENSIVE CARE (ICU) CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.27 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.28 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.

2.29 MEDICALLY NECESSARY TREATMENT is defined as any treatment, tests, 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 by 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 conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.30 MEDICAL PRACTITIONER: A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian medicine or for Homeopathy set up by the Government of India or a State Government and is there by entitled to practice medicine within its jurisdiction, and is acting within the scope and jurisdiction of license.

The term Medical Practitioner would include Physician, Specialist and Surgeon. The registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

2.31 NETWORK PROVIDER means the hospital/nursing home 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.

PPN-PREFERRED PROVIDER NETWORK means a network of hospitals which have agreed to a cashless packaged pricing for specified planned procedures for the insured person. Updated list of network provider/PPN is available on website of the company (https://nationalinsurance.co.in/tpa_ppn_network_hospital) and website of the TPA mentioned in the schedule and is subject to amendment from time to time.

2.32 NON-NETWORK HOSPITALS means any hospital, day care centre or other provider that is not part of the network.

2.33 NOTIFICATION OF CLAIM is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognized modes of communication.

2.34 OPD (Out-patient) TREATMENT means the 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 a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2.35 PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Schedule.

2.36 PORTABILITY means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

2.37 PRE-EXISTING DISEASE means any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or was diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from pre-existing disease shall be considered as a part of the pre-existing disease.

2.38 PRE-HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that

- Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and
- The In-patient Hospitalization claim for such Hospitalization is admissible by us.

2.40 POST HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 90 days after the insured person is discharged from the hospital provided that:

- Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.41 PSYCHIATRIC DISORDER means clinically significant Psychological or behavioral syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behavior or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the insured person in respect of whom a claim is lodged.

2.42 PSYCHOSOMATIC DISORDER means one or more psychological or behavioral problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after Physical examination of the insured person in respect of whom a claim is lodged.

2.43 QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

2.44 REASONABLE AND CUSTOMARY CHARGES

Reasonable and Customary charges mean 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 illness/injury involved.

2.45 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.

2.46 ROOM RENT shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

2.47 SUM INSURED is the maximum amount of coverage under this policy opted for all insured persons shown in the schedule.

2.48 SURGERY OR SURGICAL PROCEDURE means manual and /or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.49 THIRD PARTY ADMINISTRATOR (TPA) means any person who is registered under the IRDAI (Third Party Administrators-Health Services) Regulations 2016 notified by the Authority, and is engaged for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those.

2.50 UNPROVEN/EXPERIMENTAL TREATMENT means any treatment including drug experimental therapy which is not based on established medical practice in India.

2.51 WE/OUR/US/COMPANY means **NATIONAL INSURANCE COMPANY LIMITED**

3 ADDITIONAL COVERAGES:

3.1 DOMICILIARY TREATMENT:

Medical expenses incurred in case of the following diseases which need domiciliary treatment as may be certified by the attending medical practitioner and /or bank's medical officer shall be deemed as hospitalization expenses and reimbursed **to the extent of 10% subject to the overall limit of Sum Insured under the policy:**

- 1 Accidents of Serious Nature
- 2 Addison's Disease
- 3 All Animal/reptile/insect bite or sting
- 4 All Seizure disorders
- 5 Any organ related (chronic) condition
- 6 Aplastic Anemia
- 7 Arthritis
- 8 Autoimmune Myositis
- 9 Autoimmune vasculitis
- 10 Cancer
- 11 Cardiac Ailments
- 12 Celiac Disease
- 13 Cerebral Palsy
- 14 Chronic obstructive Pulmonary Disease, Chronic Bronchitis, Asthma
- 15 Chronic Pancreatitis
- 16 Connective tissue disorder
- 17 Diabetes and its complications (including Type 1 Diabetes)
- 18 Diphtheria
- 19 Epidermolysis bullosa
- 20 Exp. incurred on radiotherapy & chemotherapy in treatment of cancer and leukaemia
- 21 Glaucoma
- 22 Grave's Disease

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- 23 Growth disorders
- 24 Haemorrhages caused by accidents
- 25 Hashimoyo's Thyroiditis
- 26 Hemophilia
- 27 Hepatitis -B,Hepatitis-C
- 28 Hypertension
- 29 Hypothyroidism,hyperthyroidism
- 30 Inflammatory Bowel Disease
- 31 Kidney Ailment
- 32 Leprosy
- 33 Leukemia
- 34 Malaria
- 35 Multiple Sclerosis/Motor Neuron Disease
- 36 Muscular dystrophies
- 37 Myasthenia gravis
- 38 Non – Alcoholic Cirrhosis of Liver
- 39 Osteoporosis
- 40 Paralysis
- 41 Parkinsons's Diseases
- 42 Pernicious Anemia
- 43 Physiotherapy
- 44 Pleurisy
- 45 Polio
- 46 Psoriasis/Psoriatic Arthritis
- 47 Psychiatric disorder including Schizophrenia and Psychotherapy
- 48 Purpura
- 49 Rheumatoid Arthritis (RA)
- 50 Sickle cell disease ,systemic lupus erythematosus (SLE)
- 51 Sjogrens's Syndrome
52. Sleep apnea syndrome (not related to obesity)
53. Status asthmaticus , sequalea of neningitis
54. Swine flu
55. System Lupus Erythematosus
56. Thalassemia
57. Third Degree burns
58. Thrombo embolism venous thrombosis/venous thrombo embolism (VTE)
59. Tuberculosis
60. Tumor
61. Typhoid
62. Ulcerative Colitis
63. Varicose veins
64. Venous Thrombosis (not caused by smoking)
65. Wilson's disease
66. All strokes leading to paralysis.

The cost of medicines, investigations, and consultations etc. In respect of domiciliary treatment shall be reimbursed for the period stated by the specialist and/or the attending doctor and/or the bank's medical officer, in Prescription duly supported by relevant investigation reports wherever necessary. If no period stated, the prescription for the purpose of reimbursement shall be valid for a period not exceeding 90 days.

3.2 Domiciliary Hospitalisation means medical treatment for a period exceeding 3 days

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for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- A) The condition of the patient is such that he/she is not a condition to be removed to a hospital or
- B) The patient takes treatment at home on account of non-availability of room in a hospital.

3.3 Alternative Treatment- Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

- a. Central or State Government AYUSH Hospital; or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:

- i. Having at least 5 in-patient beds;
- ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
- iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

3.4 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	21	Haemo dialysis
2	Appendectomy	22	Fissurectomy/Fistulectomy
3	Ascitic/Pleural tapping	23	Mastoidectomy
4	Auroplasty not Cosmetic in nature	24	Hydrocele Surgeries
5	Coronary/Renal Angiography	25	Hysterectomy
6	Coronary angioplasty	26	Inguinal/ventral/mbilical/femoral hernia surgeries
7	Dental Surgery	27	Parental Chemotherapy
8	D&C	28	Polypectomy
9	Excision of cyst/granuloma/lump/tumor	29	Septoplasty
10	Eye Surgery	30	Piles/Fistula Surgeries
11	Fracture including hairline fracture/dislocation	31	Prostate surgeries

12	Radiotherapy	32	Sinusitis surgeries
13	Chemotherapy	33	Tonsillectomy
14	Lithotripsy	34	Liver aspiration
15	Incision and drainage of abscess	35	Sclerotherapy
16	Varicocelelectomy	36	Varicose Vein Ligation
17	Wound Suturing	37	All scopies along with biospies
18	FESS	38	Lumbar puncture
19	Operations/Micro Surgical operations on the nose, mouth, middle ear/internal ear, tongue, face, tonsils & adenoids, salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.	39	Treatment for Age related Macular Degeneration (ARMD) and Intra Vitreal injections for eye disorders other than ARMD also.
20	Approved targeted therapies for treatment of Cancer in day care and on standalone basis. (Immunotherapy – Monoclonal Antibody Cancer treatment on standalone basis).	-	----

This condition will also apply in case of stay in hospital of less than a day provided –

- 3.4.1 The treatment is undertaken under General or Local Anesthesia in a hospital/day care Centre in less than a day because of technological advancement and
- 3.4.2 Which would have otherwise required hospitalisation of more than a day

3.5 AMBULANCE CHARGES

Ambulance charges are payable up to Rs. 2500 per trip to hospital and/or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs. 750 per hospitalisation.

Ambulance charges actually incurred on transfer from one centre to another centre due to non-availability to medical service/medical complication shall be payable in full.

3.6 PRE EXISTING DISEASES/AILMENTS

Pre-existing diseases are covered under the scheme from day one.

3.7 CONGENITAL ANOMALIES

Expenses for treatment of congenital internal/external diseases, defects anomalies are covered under the policy

3.8 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without hospitalisation up to the sum insured.

3.9 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority e.g. Laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care

surgery.

3.10 Treatments taken for accidents can be payable even on OPD basis in a hospital upto Sum Insured.

3.11 TAXES AND OTHER CHARGES

All Taxes, Surcharges, Service charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable. Charges for diapers and sanitary pads are payable if necessary as part of treatment. Charges for hiring a nurse/attendant during hospitalisation will be payable only in case of recommendation from treating doctor in case ICU/CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.12 Treatment for Genetic disorder and stem cell therapy is covered under the scheme.

3.13 Treatment for Age related Muscular Degeneration (ARMD), treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP) and related treatments are covered under the scheme. Treatment for all neurological/macular degenerative disorders shall be covered under the scheme.

3.14 Rental charges for external and/or durable medical equipment used for diagnosis and/or treatment including CPAP, CAPD, Bi-PAP, Infusion pump and related equipment will be covered under the scheme. However, purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.15 Ambulatory devices i.e walker, crutches, belts, collars, caps, splints, braces, stockings, elasto crepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including glucose test strips) /Nebulizer/prosthetic device/Thermometer, alpha/water bed and similar items will be covered under the scheme.

3.16 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the medical practitioner even if taken at home.

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 and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of:

4.1. Investigation & Evaluation

- Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.2. Rest Cure, Rehabilitation and Respite Care

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

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.3 Change-of-Gender Treatments

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4 Stay in Hospital which is not Medically Necessary.

4.5 Self-Inflicted Injury Treatment for intentional self-inflicted injury, attempted suicide.

4.6 Birth control, Sterility and Infertility

Expenses related to sterility and infertility. This includes: i. Any type of sterilization ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI iii. Gestational Surrogacy iv. Reversal of sterilization

4.7 Refractive Error

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

4.8 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.

4.9 Drug/Alcohol Abuse

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

4.10 Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician,

Outstation doctor/surgeon/ consultants' fees and similar expenses (as listed in respective Annexure -I).

4.11 Home Visit Charges

Home visit charges during Pre and Post Hospitalisation of doctor, aya, attendant and nurse.

4.12 Breach of Law

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.13 Injury/disease directly or indirectly caused by or attributable to war, invasion, Act of Foreign Enemy, War like operations (whether war be declared or not); Nuclear radiation/weapon/materials.

4.14

- Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
- Vaccination or Inoculation
- Change of life or cosmetic or aesthetic treatment of any description is not covered.
- Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.15 Cost of spectacles and contact lenses, hearing aids, other than Intra-Ocular Lenses and Cochlear Implant.

4.16 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.17 Convalescence, rest cure, obesity treatment and its complications including morbid obesity, Venereal disease and use of intoxication drugs/alcohol.

4.18 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 Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome of a similar kind commonly referred to as AIDS.

4.19 Charges incurred at hospital/nursing home primarily for diagnosis x ray or laboratory examinations or other diagnostic studies not consistent with diagnosis and treatment of positive existence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home unless recommended by the attending doctor.

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

4.21 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, barber or beauty devices, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses unless and otherwise necessitated during the course of treatment.

4.22 Critical Illness diagnosed before the commencement of the policy are not covered.

4.23 Expenses on purchase of medicine not supported by bills/receipts/cash memos without valid GST No of the issuer of such bills/receipts/cash memos.

5. Claims Procedure

A. Claims Administration and Process

It shall be the condition precedent to admission of our Liability under this policy that the terms and conditions of making payment of premium on full or in time in so far as they relate to anything to be done or complied with by you or any Insured Person, are fulfilled including complying with the following in relation to claims ;

1. On the occurrence or discovery of any illness or injury that may give rise to a claim under this policy, the claims procedure set out below shall be followed.
2. The treatment should be taken as per the advice, directions and guidance of the treating medical practitioner. Any failure to follow such advice, directions and guidance will prejudice the claim.
3. The insured person must submit to medical examination by our medical practitioner in case requested by us and at our cost, as often as we consider reasonable and necessary and we/our representatives must be permitted to inspect the medical and hospitalisation records pertaining to the insured person's treatment and to investigate the circumstances pertaining to the claim.
4. We and our representatives must be given all reasonable cooperation in investigating the claim in order to assess our liability and quantum in respect of the claim.

Notification of Claim

Upon the happening of any event which may give rise to any claim under this policy, the insured or insured's representative shall notify the TPA in writing by letter, email, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within prescribed time limit.

Notification of Claim in case of Cashless facility	TPA must be informed:
In the event of planned hospitalisation	At least 72 hours prior to the insured person's admission to network provider/ PPN hospital
In the event of emergency hospitalisation	Within 24 hours of the insured person's admission to network provider/PPN hospital.

Notification of Claim in case of Reimbursement	TPA must be informed:
In the event of planned hospitalisation	Within 48 hours of the insured person's admission to network provider/non network/ PPN hospital
In the event of emergency hospitalisation	Within 48 hours of the insured person's admission to network provider/ non network /PPN hospital.

B. Procedure for cashless claims

1. Cashless facility for treatment shall be available to insured in network hospitals only.
2. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network providers/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (<https://nationalinsurance.nic.co.in/en/health-insurance/city-wise-list-ppn-hospitals>) and the TPA mentioned in the schedule
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN, produce the ID card issued by the TPA at the hospital helpdesk. Cashless request form available with the network provider/PPN and TPA

shall be completed and sent to TPA for authorization. Each request for pre authorization must be through duly completed standard pre-authorization format including the following details:

- i. The health card which the insurer or the associated TPA has issued to the insured person supported with KYC documents;
 - ii. The Policy Number;
 - iii. Name of the Policy/ Number/Employer;
 - iv. Name and address of insured person/Employee/member in respect of whom the request is being made;
 - v. Nature of the illness/injury and the treatment/surgery required;
 - vi. Name and address of the attending Medical Practitioner;
 - vii. Hospital where the treatment/surgery is proposed to be taken;
 - viii. Proposed date of admission;
5. If these details are not provided in full or sufficient or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.
 6. When the associated TPA has obtained sufficient details to access the request, the associated TPA will issue the authorisation letter specifying the specified amount, any specific limitation on the claim, applicable deductibles, and non-payable items if applicable, or We may reject the request for pre-authorisation specifying reason for the rejection.
 7. The TPA upon getting cashless request form and related medical information from the insured person/network hospital/PPN shall issue pre-authorisation letter to the hospital after verification.
 8. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorised treatment, including dates, hospitals and locations match with the details of the actual treatment received. For Hospitalisation where Cashless Facility is pre-authorised by the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.
 9. In the event that the cost of hospitalisation exceeds the authorised limits as mentioned in the authorisation letter:
 - a. The network provider shall request us for an enhancement of authorization limit as described under section 5.B including details of the specific circumstances which have led to the need for increase in the previously authorised limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
 - b. We shall accept or decline such request for enhancement of pre-authorised limit for enhancement

In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the insured person, the network provider shall obtain a fresh authorisation letter from us in accordance with the process described under 5.B above.

10. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.

11. At the time of discharge:

- The Network Provider may forward a final request for authorisation for any residual amount to the TPA along with the discharges summary and the detailed bill break up in accordance with the process described at 5.B.above.
- Upon receipt of the final authorisation letter from TPA, the insured person may be discharged by the Network Provider.

Note: (Applicable to 5 B): Cashless facility for hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider/PPN hospital for Illness Injury/Accident/Critical Illness as the case which may be which are covered under the policy. For all cashless authorisation, the insured person, will in any event be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and/or opted Deductible (Per Claim/Aggregate/Corporate) (if applicable), directly with the hospital.

12. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The insured person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

13. Claims for pre hospitalisation and post hospitalisation will be settled on a reimbursement basis on production of cash receipts.

C. Procedure for reimbursement of claims

In non-network hospitals payment must be made upfront and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/the bank's office authorised to deal with Health Claims within the prescribed time limit.

For all claims for which Cashless Facilities have not been pre-authorised or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

- The Policy Number;
- Name of the Policy Number/Employer;
- Name and address of Insured person/Employee/member in respect of whom the request is being made;
- Health Card, photo ID, KYC documents;
- Nature of illness or injury and the treatment/Surgery taken;
- Name and address of the attending medical practitioner;
- Hospital where treatment/surgery was taken;
- Date of Admission and Date of Discharge;
- Any other information that may be relevant to the Illness/Injury/Hospitalisation;

- x. Duly completed claim form

D. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.

- i. Duly completed claim form
- ii. Photo ID and Age Proof
- iii. Health Card, Policy copy, Photo ID and KYC documents
- iv. Attending medical practitioner's/surgeon's certificate regarding diagnosis/nature of operation performed along with date of diagnosis, investigation test reports etc supported by the prescription from attending medical practitioner
- v. Original discharge card/day care summary/transfer summary
- vi. Original final hospital bill with all original deposit and final payment receipt
- vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery
- viii. All previous consultation papers indicating history and treatment details for current ailment
- ix. All original diagnostic reports (including imaging and laboratory) along with medical practitioner's prescription and bill/invoice with receipt from diagnostic centre.
- x. All original medicine/pharmacy bills along with medical practitioner's prescription;
- xi. MLC /FIR copy- in Accidental case only;
- xii. Copy of death summary and copy of death certificate (in death claims only);
- xiii. Pre and post-operative imaging reports-in Accidental cases only;
- xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.C. & 5.D. And claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
Where Cashless Facility has been authorised	Immediately after discharge.

Reimbursement of hospitalisation and per hospitalisation expenses (limited to 30 days)	Within 30 (Thirty) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 30 (thirty) days from completion of post hospitalisation treatment.

Note: Waiver of this condition may be considered in extreme case of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

3. The insured Person shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
4. All the documents submitted to TPA shall be electronically collected by us for settlement and denial of the claims by the appropriate authority.

E. Scrutiny of Claim Documents

- a. The TPA shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/Network Provider as the case may be within 7 working days of submission of documents. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days, The TPA will send a maximum of 3 (three) reminders. We may, at our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.
- c. The Pre-Hospitalization Medical Expenses Cover claim and Post-Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

F. Claim Assessment

Insurer will pay the fixed or indemnity amount as specified in the applicable Base of Optional Cover in accordance with the terms of the Policy.

Insurer will assess all admissible claims under the Policy in the following progressive order:

- I. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.
- II. Opted Deductible (Pre Claim/Aggregate/Corporate), if any, shall be applicable on the amount payable by Us after applying (I), and (ii) above.
- III. Co-Payments if any, shall be applicable on the amount payable by us after applying (i), and (ii).

The Claim amount assessed under Section 5.F (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit.

- a. Sum Insured
- b.

G. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 24 (Twenty Four) days offer a settlement of the claim to the insured person.
2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2%(Two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later the 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.
5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7(Seven) days from the date of acceptance of the offer.
6. A claim, which is not covered under the policy cover and conditions, can be rejected.

H. Rejection/ Repudiation of Claim

- a. If the company, for any reasons, decides to reject/repudiate –a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) of investigation report (if any), as the case may be. Where a rejection is communicated by the Company, the Insured Person may, is so desired, within 15 days from the date of receipt of the claims decision represent to the Company for reconsideration of the decision.
- b. In case of rejection of claims, it would go through a committee setup of the Bank, Third Party Administrator and National Insurance Co. Ltd. unless rejected by the committee in real time the claim should not be rejected.

I. Claim Payment Terms

- I. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
- II. All claims will be payable in India and in Indian rupees.
- III. We are not obligated to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonable minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice of guidance provided by a Medical Practitioner.
- IV. The Sum insured opted under the Policy shall be reduced by the amount payable/ paid

under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

- V. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.
- VI. For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
- VII. For Reimbursement claims, the payment shall be made to the Insured person. In the unfortunate event of the Insured person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate of indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

- J. Claims will be managed through the same Office of the Bank from where it is managed at Present. The Third Party Administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

6 CONDITIONS

6.1 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 Proposer. (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)

6.2 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.

6.3 Communication

- i. All communication should be made in writing.
- ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
- iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
- iv. The Company or TPA shall communicate to the Proposer/ Insured Person at the address mentioned in the Schedule.

6.4 Physical Examination

Any Medical Practitioner authorised by the Company shall be allowed to examine the

नेशनल इन्श्योरेंस कम्पनी लिमिटेड
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Insured Person in the event of any alleged Illness/Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.5 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)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company. 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 Company or to induce the Company 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 Company.

6.6 Territorial Limit

All medical treatment for the purpose of this policy will have to be taken in India only.

6.7 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- 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 acclaim 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. After the end of the policy period, the policy can be renewed within the Grace Period of 30 days to maintain continuity benefits without break in policy. Cover age is not available during the grace period.
- v. No Loading shall apply on renewals based on individual claims experience.

6.8 Guideline for Addition of members:-

Midterm additions are allowed only for employees retired from their service during currency of the policy subject to intimation received within 30 days.

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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

6.9 Cancellation:

- i. 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
- ii. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

Period of risk	Rate of premium to be charged
Up to 1 month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

6.10 Territorial Jurisdiction

- The All disputes or differences under or in relation to the Policy shall be determined by the Indian court and according to Indian law.

6.11 Maintenance Of member Records

The Insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the Insured persons and other relevant details as are normally kept in any institution/ Organization. The Insured shall declare to the company any additions in the number of Insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

It is hereby agreed and understood that, this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to member who cease to be part of the group for any reason whatsoever.

6.12 Low Claim Ratio Discount (Bonus)

Low Claim Ratio Discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ration for the entire group Insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken in to account.

Incurred Claim Ratio under the Policy	Discount
Above 70%	Nil
66-70%	2.50%
61-65%	5%
56-60%	10%

6.13

If to to	51-55%	15%
	41-50%	25%
	31-40%	35%
	21-30%	40%
	Not exceeding 20%	50%

Arbitration

any dispute or difference shall arise as the quantum 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.

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.

6.14 Disclaimer

If the company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (12) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

6.15 IRDA Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (health Insurance) Regulations 2016 and IRDA (protection of policyholder's interest) Regulations 2017 as amended from time to time.

6.16 Grievance Redressal

In case of any grievance the insured person may contact the company through Website: <https://nationalinsurance.nic.co.in/> Post: National Insurance Co. Ltd., Toll free: 18003450330

6A Middleton Street, 7th Floor,
CRM Dept., Kolkata - 700 071
E-mail: customer.relations@nic.co.in
Phn : (033) 2283 1742

Insured person may also approach the grievance cell at any of the company's branches with the

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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 (Office in-Charge) at that location.

For updated details of grievance officer, kindly refer the link:

<https://nationalinsurance.nic.co.in/>

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 (Annexure II).

Grievance may also be lodged at IRDAI Integrated Grievance Management System -

<https://igms.irda.gov.in/>

6.17 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.

6.18 Withdrawal of Policy

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.

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.

1) "Policy Issuing Office: Mumbai"

2) " Consolidated Stamp Duty deposited as per the order of Government of India

For National Insurance Co Ltd



Authorised Signatory

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Annexure I

List I – List of which coverage is not available in the policy	
Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETER
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLEY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES

6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXIMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE/SPIRIT/ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer & Strips
18	URINE BAG

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email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

The contact details of the Insurance Ombudsman offices are as below-

Annexure II

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27- N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	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
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of 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
Tamil Nadu, UT– Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	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
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor,
	Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
	rala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry
	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
	est Bengal, UT of Andaman and Nicobar Islands, Sikkim
	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
	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Naval Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P.-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
	Bihar, Jharkhand.
	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region
	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in

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पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000295	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IIInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27 , Maharashtra GSTIN: 27AAACN9967E1Z3 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल विवरण/ <u>Sales Channel Details</u> कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0 सह दलाल कोड / Co Broker Code: कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

ग्राहक का नाम /Customer Name: PUNJAB NATIONAL BANK - RETIREES	ग्राहक आईडी /Customer ID: 9701926962	पैन /PAN: AAACP0165G
पता/ Address: SECTOR 10, PLOT NO. 4 DWARKA, City: SOUTH WEST DELHI - DISTRICT OT, District: SOUTH WEST DELHI, State: DELHI, PIN: 110075. Cell: 8860911188	फोन /Phone:	ई-मेल /E-Mail:

पॉलिसी: 01/11/2022 के 00:00 से 31/10/2023 की मध्य रात्रतिक प्रभावी /Policy Effective from 00:00 hours, on 01/11/2022 to midnight of 31/10/2023			
प्रीमियम/ Premium	₹ 10,21,20,117.00	कवर नोट संख्या और तथि/ Cover Note Number and Date	लागू नहीं/NA
CGST	₹ 0.00	प्रस्ताव संख्या और तथि/Proposal Number and Date	8800211130958609 Dt. 16/11/2022
SGST/UTGST	₹ 0.00		
IGST	₹ 1,83,81,621.00		
कम:जीएसटी टैडीएस / Less:GST_TDS	₹ 0.00	रसीद संख्या और तथि/Receipt Number and Date	251100812210002618 Dt. 31/10/2022
पुनर्प्राप्ति योग्य स्टाम्प ड्यूटी /Recoverable Stamp Duty	₹ 0.00	पछिली पॉलिसी संख्या और समाप्ति तथि/ Previous Policy Number and Expiry Date	लागू नहीं/NA
कुल /Total Amount	₹ 12,05,01,738.00	(Rupees Twelve Crore Five Lakh One Thousand Seven Hundred Thirty Eight Only.)	

Total Location Sum Insured	₹ 4,18,58,00,000.00
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LocationAddress:
1)DELHI,,New Delhi - District Others,New Delhi,Delhi,110098.

Number of families:10936 Number of Lives covered: 19586

SL. No	Coverage	Coverage Description	Sum Insured
1	Standard Cover	GMT TOP UP	4,18,58,00,000.00
	अधिक/Excess:		
	Additional Information: NA		

TPA Details: HERITAGE HEALTH TPA PVT LTD - MUMBAI MBRO I, Champion Building, Ground Floor, 15 Parsi Panchayat Road, Andheri East, Mumbai 400069 - 400069 Contact No : 22 - 28232503 Fax : 022 - 66716299 Email : heritagemumtpa@bajoria.in.

Clauses	As per Annexure I
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टिप्पणियां/ Remarks: 1. Base Policy No. : With Domiciliary Policy No.251100502210000293 & Without Domiciliary Policy no. 251100502210000294.



पॉलिसी अनुसूची/ Policy Schedule - Group Mediclaim - Tailor Made with Floater	
Policy Number: 251100502210000295	व्यवसाय स्रोत / Business Source: 251100
जारीकर्ता कार्यालय/Issuing Office कार्यालय कोड/ Office Code: 251100 कार्यालय पता/ Office Address: MUMBAI DIVISION XI IInd Floor, National Insurance Building,, 14, Jamshedji Tata Road,, Churchgate - 400020. State Code: 27 , Maharashtra GSTIN: 27AACN9967E123 Contact Number: 22 22036054 Mobile Number: 0	विक्रय चैनल विवरण/ Sales Channel Details कोड/ Code: 251100 नाम/ Name: Mumbai Division XI Contact Number: 0
	सह दलाल कोड / Co Broker Code:
	कस्टमर केयर टॉल फ्री नंबर/Customer Care Toll Free Number: 1800 345 0330 ईमेल/ email:customer.support@nic.co.in

2. Sum Insured for Group Health Insurance on Family Floater Basis:

Super Top up policy is only available to Retiree Award Staff who opt 3 lacs and Retiree Officers who opt for 4 lacs Sum Insured in Base Policy.

Award Staff can opt for 1 lac to 4 lacs Sum Insured in Super Top up policy;

Officers can avail 1 Lac to 5 lacs Sum Insured in Super Top policy.

3. Data: As per annexure attached.

4. Domiciliary Treatment Expenses are not covered under the Super Top up policy.

5. Pre & Post Hospitalization stands covered under Super Top Up policy.

जसिकी गवाही में, दिनांक/ माह/ वर्ष को उपरोक्त उल्लेखित कार्यालय पते पर अधोहस्ताक्षरी को वधिवित अधिकृत किया जा रहा है उसके हाथ नर्धारित किए जाएं। यह अनुसूची, संलग्न पॉलिसी, खण्ड, पृष्ठानकन और पॉलिसी शर्तों, जो कंपनी वेबसाईट <https://nationalinsurance.nic.co.in> पर उपलब्ध है, को एक अनुबंध के रूप में एक साथ पढ़ा जाए तथा कोई भी शब्द या अभिव्यक्ति जिसके लिए यह विशिष्ट अर्थ पॉलिसी या अनुसूची के किसी भी हिस्से में संलग्न किया गया हो, एक ही अर्थ वहन करेगा चाहे जहाँ भी उल्लेखित हो। यह आश्वासन दिया जाता है कि प्रीमियम चेक के अस्वीकृत के मामले में, यह दस्तावेज स्वतः प्रामाणिकता नरिस्त हो जाएगी। **IN WITNESS WHEREOF, the undersigned being duly authorized hereunto set his/ her hand at the office address mentioned above, this 16/November/2022. This schedule, the attached policy, the clauses, the endorsements and policy wordings as available in the website <https://nationalinsurance.nic.co.in> shall be read together as one contract and any word or expression to which the specific meaning has been attached in any part of this policy or of the schedule shall bear the same meaning wherever it may appear. It is warranted that IN CASE OF DISHONOUR OF THE PREMIUM CHEQUE, THIS DOCUMENT STANDS AUTOMATICALLY CANCELLED 'AB-INITIO'**

इंश्योरेंसइंडियालिमिटेड

स्टांप
Stamp
Duty:
(₹ 1.00)

कृते नेशनल इन्श्योरेंस कंपनी
For and on behalf of National Insurance
Company Limited
अधिकृत हस्ताक्षरकर्ता/ Authorized
Signatory

TAX INVOICE

Invoice Serial No: 30154H2P00000295

Invoice Date: 16/11/2022

Details of Supplier:

National Insurance Company Limited.,
MUMBAI DIVISION XI IInd Floor, National Insurance Building,,14, Jamshedji Tata Road,,Churchgate - 400020
State : 27, Maharashtra
GSTIN No : 27AAACN9967E1Z3

Details Of Receiver : PUNJAB NATIONAL BANK - RETIREES

Address : SECTOR 10, PLOT NO. 4 DWARKA
City : SOUTH WEST DELHI - DISTRICT OT,
District: SOUTH WEST DELHI,
State: DELHI,
PIN: 110075.

Place Of Supply State : Delhi
State Code : 7
GSTIN No : 07AAACP0165G1ZR

सैंक कोड/ SAC Code	सेवा का विवरण/ Description of Service	कुल/Total(₹)	छूट/ Discount	टैक्स योग्य/ मूल्य/Taxable Value(₹)	सीजीएसटी की राशि/ CGST		एसजीएसटी/यूटीजीएसटी/ SGST/UTGST		आईजीएसटी/IGST		केरला बाढ़ उपकर/Kerala Flood Cess
					दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	दर/Rate	राशि/ Amount(₹)	राशि/Amount(₹)
997139	Other non-life insurance services (excluding reinsurance services)	10,21,20,117	0%	10,21,20,117	0%	0	0%	0	18%	1,83,81,621	0
TOTAL		10,21,20,117		10,21,20,117		0		0		1,83,81,621	0

कुल इनवॉयस मूल्य (अंकों में) Total Invoice Value (In figures) :
₹ 12,05,01,738

कुल इनवॉयस मूल्य (शब्दों में) Total Invoice Value (In words) : रूपा/Rupees
Twelve Crore Five Lakh One Thousand Seven Hundred Thirty Eight
केवल/Only.

रिवर्स चार्ज के अधीन टैक्स की राशि Amount of Tax Subject to Reverse Charge : No

E.&O.E

कृते नेशनल इन्श्योरेंस कंपनी लिमिटेड/ For
and on behalf of National Insurance Company Limited

अधिकृत हस्ताक्षरकर्ता/ Authorized Signatory



Part – II**1 RECITAL CLAUSE**

- 1.1 Whereas the Proposer designated in the Schedule hereto has by a proposal together with declaration, which shall be the basis of this Contract and is deemed to be in corporate herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1.2 OPERATIVE CLAUSE

The Company undertakes that if during the Policy Period stated in the Schedule, any Insured Person(s) shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury), requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub-limits contained herein as well as shown in the following sections, and shall not exceed the floater Sum Insured in respect of insured person(s) covered under the policy.

Important:

1. Claim shall be admissible for the hospitalisation during which the cumulative medical expenses in respect of hospitalisation(s) of any insured person in policy period exceeds the base Sum insured and Corporate buffer and for all subsequent hospitalisation(s) during the policy period.
2. For claims admissible under the policy (after Medical Expenses exceeds the base Sum Insured) Coverage mentioned in both Section 1.3 and Section 3 shall be payable.
3. Maximum liability of the Company under the policy for all admissible claims during the policy period shall be floater sum insured opted.
4. The insured shall preserve and submit all original documents and/or certified copies of documents related to all hospitalisation(s) during the policy period to enable the company to calculate the cumulative medical expenses and base Sum Insured, for determining admissibility and payment of claims.

1.3 BASIC COVER:

1.3.1 In the event of any claim becoming admissible under this scheme, the company will pay 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.

A) Room and boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the Schedule or the actual amount whichever is less.

B) Intensive care Unit (ICU) expenses not exceeding per day limit as mentioned in the Schedule or actual amount whichever is less.

नेशनल इन्श्योरेंस कम्पनी लिमिटेड
National Insurance Company Limited
CIN : U10200WB1906G01001713
IRDA Registration No. 58



ATTACHED TO AND FORMING PART OF IBA RETIREES' TOP UP POLICY 2022-23

- C) Surgeon, team of surgeons, Assistant surgeon, Anesthetist, Medical Practitioner Consultants, Specialists Fees.
- D) Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO Charges, Aesthetic, Oxygen, Blood, Operation Theatre Charges, surgical appliances, OT Consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, Orthopedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve replacements, vascular stents, any other valve replacement, Laboratory/Diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.
- E) Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured.

1.3.2 Pre-Hospitalization and Post- Hospitalization Expenses – Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period up to 30 days prior to hospitalization and during the period up to 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalization claim is admissible under the policy.

2. Definitions:

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

2.2 ALTERNATIVE TREATMENTS-Alternative treatments are forms of treatment other than treatment "Allopathic" or "Modern medicine" and includes Ayurveda, Unani, Siddha, Naturopathy and Homeopathy in the Indian context.

2.3 ANY ONE ILLNESS will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment has been taken.

2.4 CANCELLATION defines the terms on which the policy contract can be terminated either by the insurer or the insured person by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payment of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre – authorization approved.

2.6 CONGENITAL ANOMALY refers to a condition(s) which is present since birth and which is abnormal with reference to form, structure or position.

1 Internal Congenital Anomaly -

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

2 External Congenital Anomaly -

Which is in the visible and accessible parts of the body.

2.7 CONDITION PRECEDENT shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional.

2.8 CONTINUOUS COVERAGE means uninterrupted coverage of the insured person under our Individual Health Insurance Policies or Family Floater policy from the time the coverage incepted under the policy, provided a break in the insurance period not exceeding thirty days being grace period shall not be reckoned as an interruption in coverage for the purposes of this clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest sum insured would be reckoned for determining continuous coverage.

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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

However, the benefit of Continuous Coverage getting carried over from other policies will not be available for HIV/AIDS coverage.

2.9 DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical set – up 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:

- a. Has qualified nursing staff under its employment.
- b. Has qualified Medical practitioner(s) in charge
- c. Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

2.10 DAY CARE TREATMENT-Day Care Treatment means the medical treatment and / or surgical procedure which is-

- i) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and
- ii) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

2.11 DEDUCTIBLE is a cost sharing requirement under a Health Insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.12 DENTAL TREATMENT means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.13 DISCLOSURE TO INFORMATION NORM: 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.

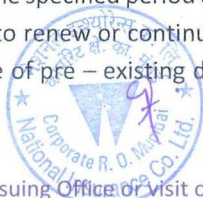
2.14 EMERGENCY CARE means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

2.15 EMERGENCY DENTAL TREATMENT means the services or supplies provided by a Licensed dentist, Hospital or other provider that are medically and immediately necessary to treat dental problems resulting from injury. However, this definition shall not include any treatment taken for a pre-existing condition.

2.16 EMERGENCY MEDICAL TREATMENT means the services or supplies provided by a Physician, Hospital or Licensed provider that are medically necessary to treat any illness or other covered condition that is acute (onset is sudden and unexpected), considered life threatening and one which if left untreated, could deteriorate resulting in serious and irreparable harm.

2.17 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

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National Insurance Company Limited
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no premium is received.

2.18 HOSPITAL/NURSING HOME 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 a 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.

For Ayurveda, Unani, Siddha, Naturopathy and Homeopathy treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.2 below.

2.19 HOSPITALISATION

Means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive "In-patient care" hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

For the list of these specified day care procedures/treatments, please see 3.3.

Note: Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.

2.20 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in network provider.

2.21 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.

(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:

- It needs ongoing or long term monitoring through consultations, examinations, check- ups, and/or tests.
- It needs ongoing or long term control or relief of symptoms.
- It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
- It continues indefinitely.
- It recurs or is likely to recur.

2.22 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.

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National Insurance Company Limited
CIN : U10200WB1906G01001713
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पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

2.23 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.

2.24 INSURED PERSON means the employee of the bank and each of the other family members who are covered under this policy as shown in the Schedule.

2.25 INTENSIVE CARE UNIT means an identified 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.

2.26 INTENSIVE CARE (ICU) CHARGES means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.27 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.28 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.

2.29 MEDICALLY NECESSARY TREATMENT is defined as any treatment, tests, 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 by 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 conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.30 MEDICAL PRACTITIONER: A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian medicine or for Homeopathy set up by the Government of India or a State Government and is there by entitled to practice medicine within its jurisdiction, and is acting within the scope and jurisdiction of license.

The term Medical Practitioner would include Physician, Specialist and Surgeon. The registered Medical Practitioner should not be the insured or any member of his family including parents and in-laws.

2.31 NETWORK PROVIDER means the hospital/nursing home 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.

PPN-PREFERRED PROVIDER NETWORK means a network of hospitals which have agreed to a cashless packaged pricing for specified planned procedures for the insured person. Updated list of network provider/PPN is available on website of the company (<https://nationalinsurance.co.in/tpa-ppn-network-hospital>) and website.

CIN : U10200WB1906GG01001713

IRDA Registration No. 58



5

पंजीकृत एवं प्रधान कार्यालय : 3 मिडिलटन स्ट्रीट, कोलकाता-700 071.
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ATTACHED TO AND FORMING PART OF IBA RETIREES' TOP UP POLICY 2022-23

of the TPA mentioned in the schedule and is subject to amendment from time to time.

2.32 NON-NETWORKHOSPITALS means any hospital, day care centre or other provider that is not part of the network.

2.33 NOTIFICATION OF CLAIM is the process of notifying a claim to the insurer or TPA within specified timelines through any of the recognized modes of communication.

2.34 OPD (Out-patient) TREATMENT means the 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 a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

2.35 PERIOD OF INSURANCE means the period for which this policy is taken and is in force as specified in the Schedule.

2.36 PORTABILITY means transfer by an Individual Health Insurance Policyholder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

2.37 PRE-EXISTING DISEASE means any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or was diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer. Any complication arising from pre-existing disease shall be considered as a part of the pre-existing disease.

2.38 PRE-HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that

- Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalization was required; and
- The In-patient Hospitalization claim for such Hospitalization is admissible by us.

2.40 POST HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 90 days after the insured person is discharged from the hospital provided that:

- Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by us.

2.41 PSYCHIATRIC DISORDER means clinically significant Psychological or behavioral syndrome that causes significant distress, disability or loss of freedom (and which is not merely a socially deviant behavior or an expected response to a stressful life event) as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the insured person in respect of whom a claim is lodged.

2.42 PSYCHOSOMATIC DISORDER means one or more psychological or behavioral problems that adversely and significantly affect the course and outcome of general medical condition or that significantly increase a person's risk of an adverse outcome as certified by a Medical Practitioner specialized in the field of Psychiatry after physical examination of the insured person in respect of whom a claim is lodged.

IRDA Registration No. 58

Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

2.43 QUALIFIED NURSE means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State in India.

2.44 REASONABLE AND CUSTOMARY CHARGES

Reasonable and Customary charges mean 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 illness/injury involved.

2.45 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.

2.46 ROOM RENT shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

2.47 SUM INSURED is the maximum amount of coverage under this policy opted for all insured persons shown in the schedule.

2.48 SURGERY OR SURGICAL PROCEDURE means manual and /or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.49 THIRD PARTY ADMINISTRATOR (TPA) means any person who is registered under the IRDAI (Third Party Administrators-Health Services) Regulations 2016 notified by the Authority, and is engaged for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those.

2.50 UNPROVEN/EXPERIMENTAL TREATMENT means any treatment including drug experimental therapy which is not based on established medical practice in India.

2.51 WE/OUR/US/COMPANY means **NATIONAL INSURANCE COMPANY LIMITED**

3 ADDITIONAL COVERAGES:

3.1 Domiciliary Hospitalisation means medical treatment for a period exceeding 3 days for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- A) The condition of the patient is such that he/she is not in a condition to be removed to a hospital or
- B) The patient takes treatment at home on account of non-availability of room in hospital.

3.2 Alternative Treatment- Subject to the condition that the hospitalisation expenses are admissible only when the treatment has been undergone in:

- a. Central or State Government AYUSH Hospital; or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

- iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

3.3 Expenses on Hospitalization for minimum period of a day are admissible. However, this time limit is not applied to specific treatments, such as

1	Adenoidectomy	21	Haemo dialysis
2	Appendectomy	22	Fissurectomy/Fistulectomy
3	Ascitic/Pleural tapping	23	Mastoidectomy
4	Auroplasty not Cosmetic in nature	24	Hydrocele Surgeries
5	Coronary/Renal Angiography	25	Hysterectomy
6	Coronary angioplasty	26	Inguinal/ventral/mbilical/femoral hernia surgeries
7	Dental Surgery	27	Parental Chemotherapy
8	D&C	28	Polypectomy
9	Excision of cyst/granuloma/lump/tumor	29	Septoplasty
10	Eye Surgery	30	Piles/Fistula Surgeries
11	Fracture including hairline fracture/dislocation	31	Prostate surgeries
12	Radiotherapy	32	Sinusitis surgeries
13	Chemotherapy	33	Tonsillectomy
14	Lithotripsy	34	Liver aspiration
15	Incision and drainage of abscess	35	Sclerotherapy
16	Varicocelelectomy	36	Varicose Vein Ligation
17	Wound Suturing	37	All scopies along with biospies
18	FESS	38	Lumbar punture
19	Operations/Micro Surgical operations on the nose, mouth, middle ear/internal ear, tongue, face, tonsils & adenoids, salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.	39	Treatment for Age related Macular Degeneration (ARMD) and Intra Vitreal injections for eye disorders other than ARMD also
20	Approved targeted therapies for treatment of Cancer in day care and on standalone basis. (Immunotherapy – Monoclonal Antibody Cancer treatment on standalone basis).	-	--

This condition will also apply in case of stay in hospital of less than a day provided –

- The treatment is undertaken under General or Local Anesthesia in a hospital/day care Centre in less than a day because of technological advancement and
- Which would have otherwise required hospitalisation of more than a day

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3.4 AMBULANCE CHARGES

Ambulance charges are payable up to Rs. 2500 per trip to hospital and/or transfer to another hospital or transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to Rs. 750 per hospitalisation.

Ambulance charges actually incurred on transfer from one centre to another centre due to non-availability to medical service/medical complication shall be payable in full.

3.5 PRE EXISTING DISEASES/AILMENTS

Pre-existing diseases are covered under the scheme from day one.

3.6 CONGENITAL ANOMALIES

Expenses for treatment of congenital internal/external diseases, defects anomalies are covered under the policy

3.7 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without hospitalisation up to the sum insured.

3.8 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority eg. Laser surgery, stem cell therapy for treatment of a disease is payable on hospitalisation/day care surgery.

3.9 Treatments taken for accidents can be payable even on OPD basis in a hospital upto Sum Insured**3.10 TAXES AND OTHER CHARGES**

All Taxes, Surcharges, Service charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable.

Charges for diapers and sanitary pads are payable if necessary as part of treatment. Charges for hiring a nurse/attendant during hospitalisation will be payable only in case of recommendation from treating doctor in case ICU/CCU, Neo natal nursing care or any other case where the patient is critical and requiring special care.

3.11 Treatment for Genetic disorder and stem cell therapy is covered under the scheme.

3.12 Treatment for Age related Muscular Degeneration (ARMD), treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP) and related treatments are covered under the scheme. Treatment for all neurological/macular degenerative disorders shall be covered under the scheme.

3.13 Rental charges for external and/or durable medical equipment used for diagnosis and/or treatment including CPAP, CAPD, Bi-PAP, Infusion pump and related equipment will be covered under the scheme. However, purchase of the above equipment to be subsequently used at home in exceptional cases on medical advice shall be covered.

3.14 Ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, braces, stockings, elastocrepe bandages, external orthopaedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer (including glucose test strips) /Nebulizer/prosthetic device/Thermometer, alpha/water bed and similar items will be covered under the scheme.

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3.15 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the medical practitioner even if taken at home.

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 and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of:

4.1. Investigation & Evaluation

- a) Expenses related to any admission primarily for diagnostics 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.

4.2. Rest Cure, Rehabilitation and Respite Care

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

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.3. Change-of-Gender Treatments

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

4.5. Self-Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.6. Birth control, Sterility and Infertility

Expenses related to sterility and infertility. This includes: i. Any type of sterilization ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI iii. Gestational Surrogacy iv. Reversal of sterilization

4.7. Refractive Error

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

4.8. 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.

4.9. Drug/Alcohol Abuse

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

4.10. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician.

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Outstation doctor/surgeon/ consultants' fees and similar expenses (as listed in respective Annexure-I).

4.11. Home Visit Charges

Home visit charges during Pre and Post Hospitalisation of doctor, aya, attendant and nurse.

4.12. Breach of Law

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.13 Injury/disease directly or indirectly caused by or attributable to war, invasion, Act of Foreign Enemy, War like operations (whether war be declared or not); Nuclear radiation/weapon/materials.

4.14

- Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
- Vaccination or Inoculation
- Change of life or cosmetic or aesthetic treatment of any description is not covered.
- Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

4.15 Cost of spectacles and contact lenses, hearing aids, other than Intra-Ocular Lenses and Cochlear Implant.

4.16 Dental treatment or surgery of any kind which are done in a dental clinic and those that are cosmetic in nature.

4.17 Convalescence, rest cure, obesity treatment and its complications including morbid obesity, Venereal disease and use of intoxication drugs/alcohol.

4.18 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 Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome of a similar kind commonly referred to as AIDS.

4.19 Charges incurred at hospital/nursing home primarily for diagnosis x ray or laboratory examinations or other diagnostic studies not consistent with diagnosis and treatment of positive existence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home unless recommended by the attending doctor.

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

4.21 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, barber or beauty devices, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses unless and otherwise necessitated during the course of treatment.

4.22 Critical illness diagnosed before the commencement of the policy are not covered.

4.23 Expenses on purchase of medicine not supported by bills/receipts/cash memos without valid GST No of the issuer of such bills/receipts/cash memos.

4.24 Domiciliary treatment : Any expenses incurred on Domiciliary treatment as mentioned in Section 3.1 of Base policy are not covered.

5. Claims Procedure

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A. Claims Administration and Process

It shall be the condition precedent to admission of our Liability under this policy that the terms and conditions of making payment of premium on full or in time in so far as they relate to anything to be done or complied with by you or any Insured Person, are fulfilled including complying with the following in relation to claims ;

1. On the occurrence or discovery of any illness or injury that may give rise to a claim under this policy, the claims procedure set out below shall be followed.
2. The treatment should be taken as per the advice, directions and guidance of the treating medical practitioner. Any failure to follow such advice, directions and guidance will prejudice the claim.
3. The insured person must submit to medical examination by our medical practitioner in case requested by us and at our cost, as often as we consider reasonable and necessary and we/our representatives must be permitted to inspect the medical and hospitalisation records pertaining to the insured person's treatment and to investigate the circumstances pertaining to the claim.
4. We and our representatives must be given all reasonable cooperation in investigating the claim in order to assess our liability and quantum in respect of the claim.

Notification of Claim

Upon the happening of any event which may give rise to any claim under this policy, the insured or insured's representative shall notify the TPA in writing by letter, email, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within prescribed time limit.

Notification of Claim in case of Cashless facility	TPA must be informed:
In the event of planned hospitalisation	At least 72 hours prior to the insured person's admission to network provider/ PPN hospital
In the event of emergency hospitalisation	Within 24 hours of the insured person's admission to network provider/PPN hospital.
Notification of Claim in case of Reimbursement	TPA must be informed:
In the event of planned hospitalisation	Within 48 hours of the insured person's admission to network provider/non network/ PPN hospital
In the event of emergency hospitalisation	Within 48 hours of the insured person's admission to network provider/ non network /PPN hospital.

B. Procedure for cashless claims

1. Cashless facility for treatment shall be available to insured in network hospitals only.
2. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network providers/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (<https://nationalinsurance.nic.co.in/en/health-insurance/city-wise-list-ppn-hospitals>) and the TPA mentioned in the schedule
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN, produce the ID card issued by the TPA at the hospital helpdesk.

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authorization format including the following details:

- i. The health card which the insurer or the associated TPA has issued to the insured person supported with KYC documents;
 - ii. The Policy Number;
 - iii. Name of the Policy/ Number/Employer;
 - iv. Name and address of insured person/Employee/member in respect of whom the request is being made;
 - v. Nature of the illness/injury and the treatment/surgery required;
 - vi. Name and address of the attending Medical Practitioner;
 - vii. Hospital where the treatment/surgery is proposed to be taken;
 - viii. Proposed date of admission;
5. If these details are not provided in full or sufficient or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.
 6. When the associated TPA has obtained sufficient details to access the request, the associated TPA will issue the authorisation letter specifying the specified amount, any specific limitation on the claim, applicable deductibles, and non-payable items if applicable, or We may reject the request for pre-authorisation specifying reason for the rejection.
 7. The TPA upon getting cashless request form and related medical information from the insured person/network hospital/PPN shall issue pre-authorisation letter to the hospital after verification.
 8. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorised treatment, including dates, hospitals and locations match with the details of the actual treatment received. For Hospitalisation where Cashless Facility is pre-authorised by the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.
 9. In the event that the cost of hospitalisation exceeds the authorised limits as mentioned in the authorisation letter:
 - a. The network provider shall request us for an enhancement of authorization limit as described under section 5.B including details of the specific circumstances which have led to the need for increase in the previously authorised limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
 - b. We shall accept or decline such request for enhancement of pre-authorised limit for enhancement. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the insured person, the network provider shall obtain a fresh authorisation letter from us in accordance with the process described under 5.B above.
 10. At the time of discharge, the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
 11. At the time of discharge:
 - a. The Network Provider may forward a final request for authorisation for any residual amount to the TPA along with the discharges summary and the detailed bill break up in accordance with the process described at 5.B above.
 - b. Upon receipt of the final authorisation letter from TPA, the insured person may be discharged by the

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Note: (Applicable to 5 B): Cashless facility for hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Provider/PPN hospital for Illness or Injury/Accident/Critical Illness as the case which may be which are covered under the policy. For all cashless authorisations, the insured person, will in any event be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and/or opted Deductible (Per Claim/Aggregate/Corporate) (if applicable), directly with the hospital.

12. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The insured person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.
13. Claims for pre hospitalisation and post hospitalisation will be settled on a reimbursement basis on production of cash receipts.

C. Procedure for reimbursement of claims

In non-network hospitals payment must be made upfront and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/the bank's office authorised to deal with Health Claims within the prescribed time limit.

For all claims for which Cashless Facilities have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

- i. The Policy Number;
- ii. Name of the Policy Number/Employer;
- iii. Name and address of Insured person/Employee/member in respect of whom the request is being made;
- iv. Health Card, photo ID, KYC documents;
- v. Nature of illness or injury and the treatment/Surgery taken;
- vi. Name and address of the attending medical practitioner;
- vii. Hospital where treatment/surgery was taken;
- viii. Date of Admission and Date of Discharge;
- ix. Any other information that may be relevant to the Illness/Injury/Hospitalisation;
- x. Duly completed claim form

D. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.
 - i. Duly completed claim form
 - ii. Photo ID and Age Proof
 - iii. Health Card, Policy copy, Photo ID and KYC documents
 - iv. Attending medical practitioner's/surgeon's certificate regarding diagnosis/nature of operation performed along with date of diagnosis, investigation test reports etc supported by the prescription from attending medical practitioner
 - v. Original discharge card/day care summary/transfer summary

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- surgeries i.e. lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery
- viii. All previous consultation papers indicating history and treatment details for current ailment
 - ix. All original diagnostic reports (including imaging and laboratory) along with medical Practitioner's prescription and bill/invoice with receipt from diagnostic centre.
 - x. All original medicine/pharmacy bills along with medical practitioner's prescription;
 - xi. MLC / FIR copy- in Accidental case only;
 - xii. Copy of death summary and copy of death certificate (in death claims only);
 - xiii. Pre and post-operative imaging reports-in Accidental cases only;
 - xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.C. & 5.D. And claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and per hospitalisation expenses (limited to 30 days)	Within 30 (Thirty) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 30 (thirty) days from completion of post hospitalisation treatment.

Note: Waiver of this condition may be considered in extreme case of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

- 3. The insured Person shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
- 4. All the documents submitted to TPA shall be electronically collected by us for settlement and denial of the claims by the appropriate authority.

E. Scrutiny of Claim Documents

- a. The TPA shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/Network Provider as the case may be within 7 working days of submission of documents. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days, The TPA will send a maximum of 3 (three) reminders. We may, at our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.

- b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization

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has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

- c. The Pre-Hospitalization Medical Expenses Cover claim and Post-Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

F. Claim Assessment

Insurer will pay the fixed or indemnity amount as specified in the applicable Base of Optional Cover in accordance with the terms of the Policy.

Insurer will assess all admissible claims under the Policy in the following progressive order:

- I. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.
- II. Opted Deductible (PreClaim/Aggregate/Corporate), if any, shall be applicable on the amount payable by Us after applying (I), and (ii) above.
- III. Co-Payments if any, shall be applicable on the amount payable by us after applying (i), and (ii).

The Claim amount assessed under Section 5.F (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit.

- a. Sum Insured

G. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 24 (Twenty Four) days offer a settlement of the claim to the insured person.
2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2% (Two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.
5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7 (Seven) days from the date of acceptance of the offer.
6. A claim, which is not covered under the policy cover and conditions, can be rejected.

H. Rejection/ Repudiation of Claim

- a. If the company, for any reasons, decides to reject/repudiate – a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) of investigation report (if any), as the case may be. Where a rejection is communicated by the Company, the Insured Person may, as so desired, within 15 days from the date of receipt of the claim decision letter present to the Company for reconsideration of the decision.

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- b. In case of rejection of claims, it would go through a committee setup of the Bank, Third Party Administrator and National Insurance Co. Ltd. unless rejected by the committee in real time the claim should not be rejected.

I. Claim Payment Terms

- I. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
- II. All claims will be payable in India and in Indian rupees.
- III. We are not obligated to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice of guidance provided by a Medical Practitioner.
- IV. The Sum insured opted under the Policy shall be reduced by the amount payable/ paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
- V. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.
- VI. For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
- VII. For Reimbursement claims, the payment shall be made to the Insured person. In the unfortunate event of the Insured person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate of indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

J. Claims will be managed through the same Office of the Bank from where it is managed at Present. The Third Party Administrator will be setting up a help desk at that office and supporting the bank in clearing all the claims on real time basis.

6 CONDITIONS

6.1 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 Proposer. (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)

6.2 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.

6.3 Communication

- i. All communication should be made in writing.
- ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
- iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

नॅशनल इन्श्योरेंस कम्पनी लिमिटेड
National Insurance Company Limited
CIN : U10200WB1906G01001713
IRDA Registration No. 58



ATTACHED TO AND FORMING PART OF IBA RETIREES' TOP UP POLICY 2022-23

iv. The Company or TPA shall communicate to the Proposer/ Insured Person at the address mentioned in the Schedule.

6.4 Physical Examination

Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured Person in the event of any alleged Illness/Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.5 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)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company. 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 Company or to induce the Company to issue an Insurance Policy:

- The suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- The active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- 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 Company.

6.6 Territorial Limit

All medical treatment for the purpose of this policy will have to be taken in India only.

6.7 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- The company shall endeavour to give notice for renewal. However, the company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made acclaim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the company before the end of the policy period.
- After the end of the policy period, the policy can be renewed within the Grace Period of 30 days to maintain continuity benefits without break in policy. Cover age is not available during the grace period.
- No Loading shall apply on renewals based on individual claims experience.

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18

पंजीकृत एवं प्रधान कार्यालय : 3 मिडिल्टन स्ट्रीट, कोलकाता 700 071.
Registered & Head Office : 3, Middleton Street, Kolkata - 700 071.
P No : 033- 22831705-06 Fax : 033-22831712
email : website.administrator@nic.co.in

For any information please contact the Policy Issuing Office or visit our website at www.nationalinsuranceindia.com

Applicable to Receipts and Policies : Incase of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".

6.8 Guideline for Addition of members:-

Midterm additions are allowed only for employees retired from their service during currency of the policy subject to intimation received within 30 days.

6.9 Cancellation:

- 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
- The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period of risk	Rate of premium to be charged
Up to 1 month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

6.10 Territorial Jurisdiction

The All disputes or differences under or in relation to the Policy shall be determined by the Indian court and according to Indian law.

6.11 Maintenance of member Records

The Insured shall throughout the period of insurance keep and maintain a proper record of register containing the names of all the Insured persons and other relevant details as are normally kept in any institution/ Organization. The Insured shall declare to the company any additions in the number of Insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

It is hereby agreed and understood that, this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to member who cease to be part of the group for any reason whatsoever.

6.12 Low Claim Ratio Discount (Bonus)

Low Claim Ratio Discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claim ration for the entire group Insured under the Group Mediclaim Insurance Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal where the Group Mediclaim Insurance Policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken in to account.

Incurred Claim Ratio under the Policy	Discount
Above 70%	Nil
66-70%	2.50%
61-65%	5%
56-60%	10%
51-55%	15%
41-50%	25%
31-40%	35%
21-30%	40%

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Not exceeding 20%

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email : website.administrator@nic.co.in

6.13 Arbitration

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.

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.

6.14 Disclaimer

If the company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (12) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

6.15 IRDA Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (health Insurance) Regulations 2016 and IRDA (protection of policyholder's interest) Regulations 2017 as amended from time to time.

6.16 Grievance Redressal

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

<https://nationalinsurance.nic.co.in/> Post: National Insurance Co. Ltd.,

Toll free: 18003450330

6A Middleton Street, 7th Floor,

CRM Dept., Kolkata - 700 071

E-mail: customer.relations@nic.co.in

Phn : (033) 2283 1742

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 (Office in-Charge) at that location.

For updated details of grievance officer, kindly refer the link: <https://nationalinsurance.nic.co.in/>

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 (Annexure II).

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

6.17 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.

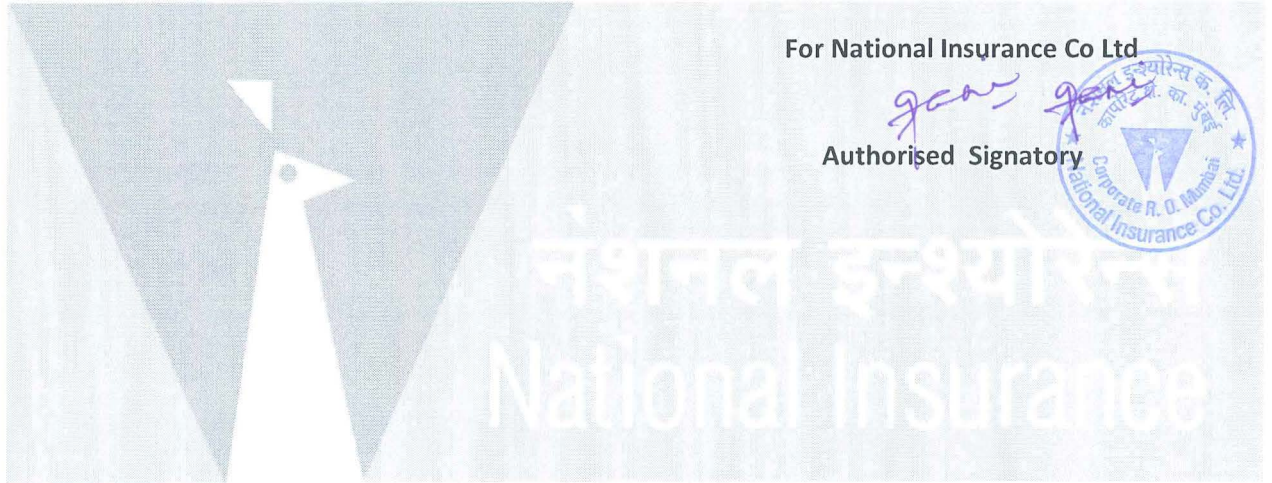
6.18 Withdrawal of Policy

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.

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.

1) "Policy Issuing Office: Mumbai"

2) " Consolidated Stamp Duty deposited as per the order of Government of India



For National Insurance Co Ltd

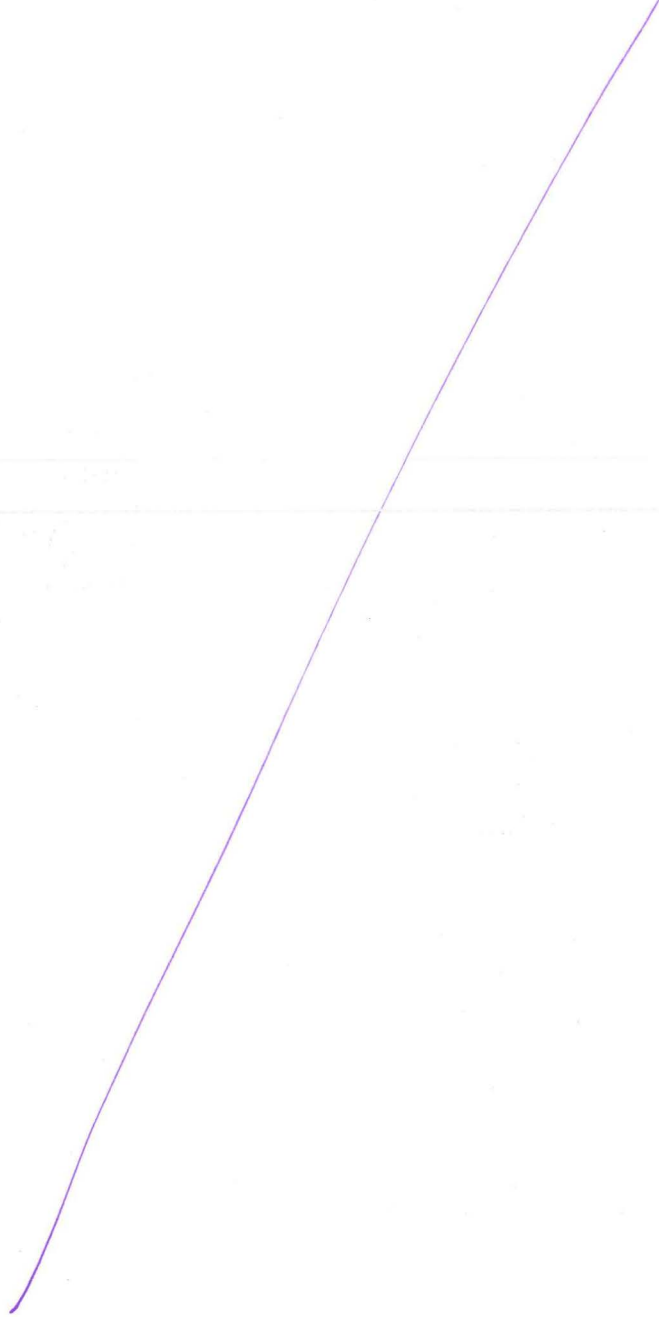
Authorised Signatory



नेशनल इन्श्योरेंस कम्पनी लिमिटेड
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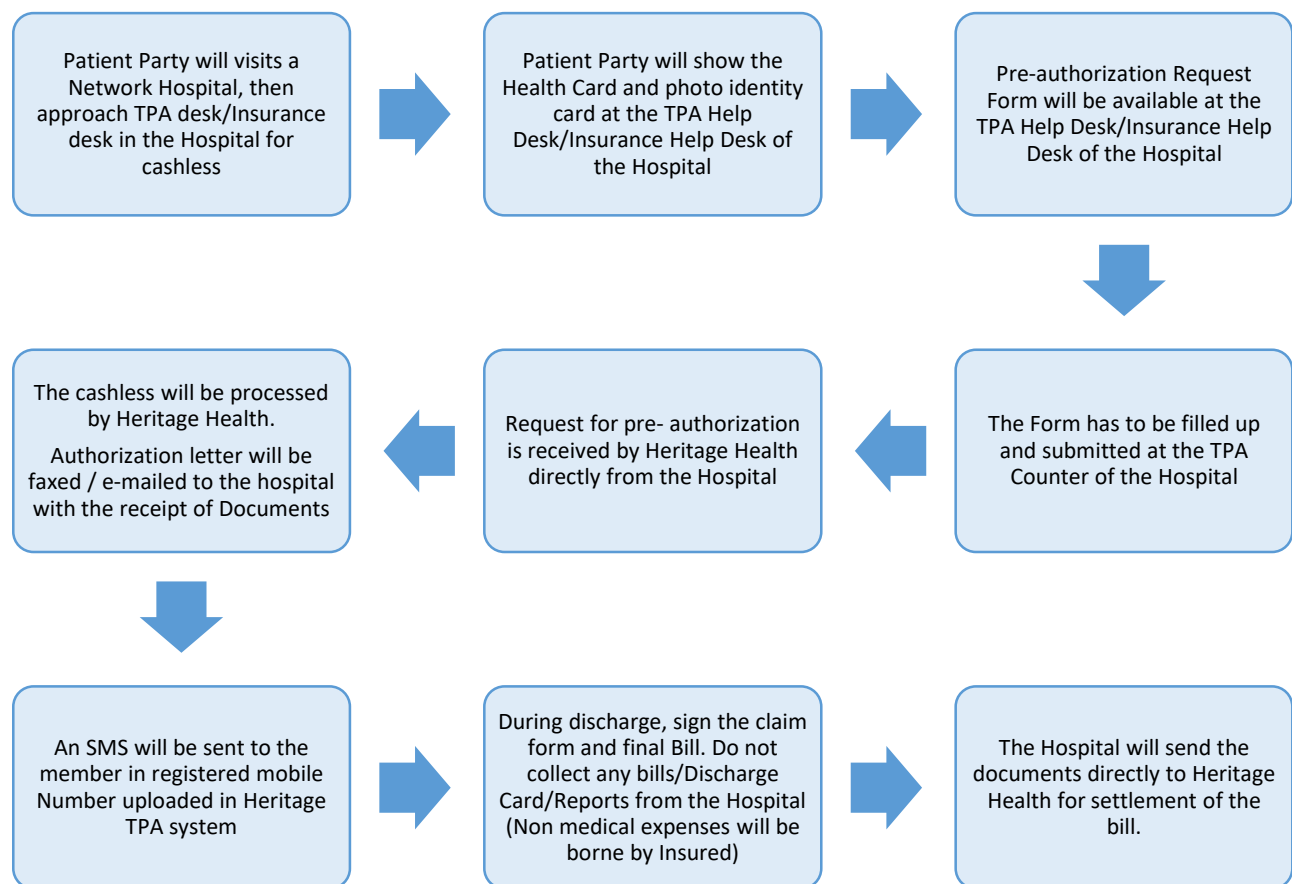
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Applicable to Receipts and Policies : In case of dishonour of Cheque / DD for Premium, the Policy / Receipt stands cancelled "ABINITIO".



Heritage Health Insurance TPA Pvt. Ltd.

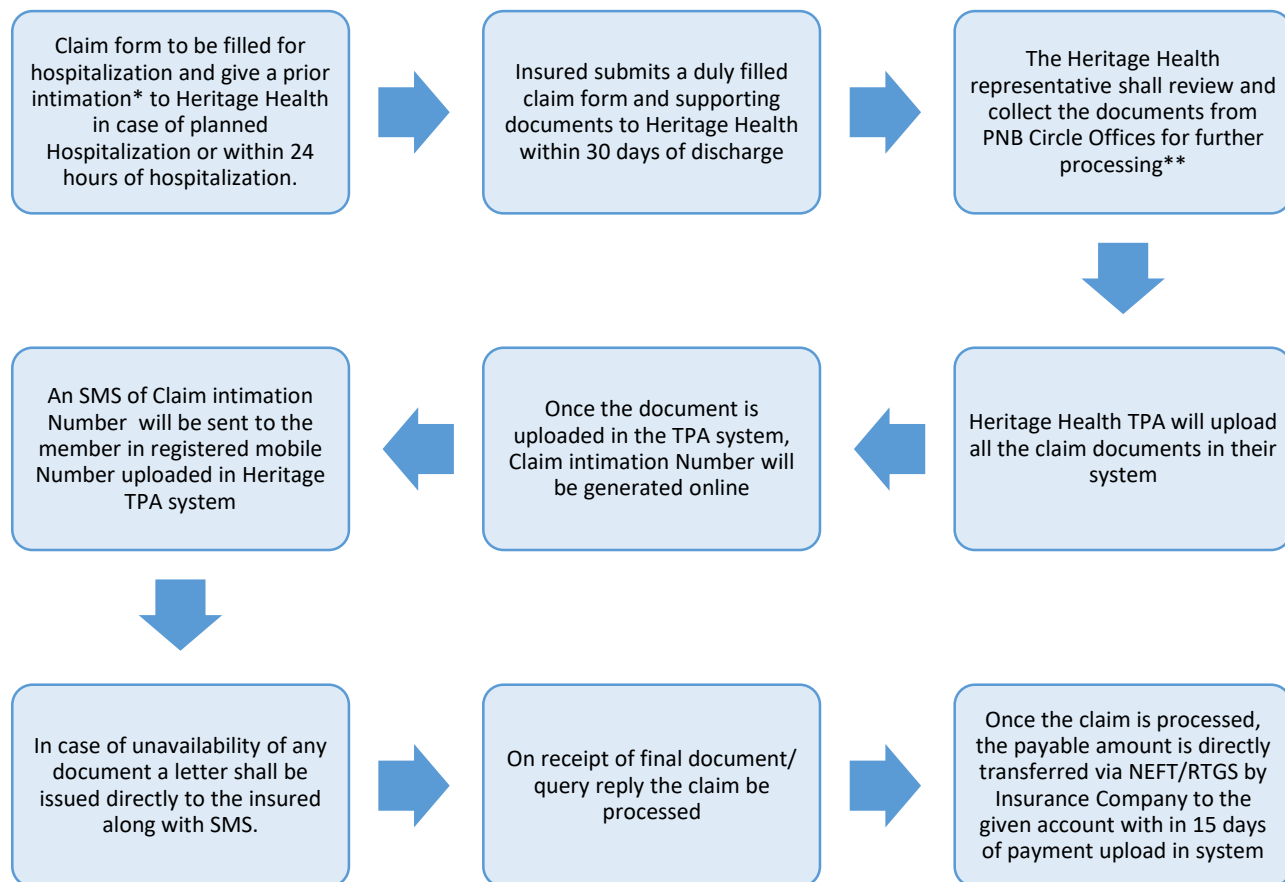
Cashless Procedure:





Heritage Health Insurance TPA Pvt. Ltd.

Reimbursement Procedure:



Note: Claims will be processed as per Policy Terms and Conditions of the Policy.

* Claim intimation can be done at Toll Free No.- 1800 1024 547 or at Email- pnb.heritage@bajoria.in ; heritagedelhibank@gmail.com

** Checklist for claim reimbursement as per annexure III



Heritage Health Insurance TPA Pvt. Ltd.

IBA GMC Policy Check List

Please find the details while claiming in Cashless, Reimbursement and Domiciliary.

For claiming Cashless

1. Ensuring if the hospital is in empanelment with the TPA. For empanelled hospital, link is http://223.31.103.204/HeritageHealthTPA/Home/Empaneled_Hospitals1.aspx

2. If cashless is entertained in our empanelled hospital, kindly request to process the Pre-auth with the employee SR number to cashlesskolkata@heritagehealthtpa.co.in

For Claiming Reimbursement

Further in case of PPN Procedures in GIPSA PPN Network Hospital, same Package rates will apply in both Cashless & Reimbursement claims subject to limit/sublimit in the policy.

Claim Intimation Copy duly received by TPA.(For planned hospitalization minimum 72hrs before from date of Admission & For Emergency hospitalization with in 24hrs from date of Admission).

All supporting documents relating to claim must be filed with the office of the Bank or TPA within 30 days from date of discharge. In post hospitalization, all claim documents should be submitted within 30 days after completion of such treatment.

Exact reason of delay in submission of documents/intimation copy, if not submitted timely as per Policy terms & conditions

1. Duly filled Original claim form & signed by the beneficiary.
 - a. --Claim Form A (by insured)
 - b. --Claim Form B (by Hospital)
 ,with Claimant Signature mentioning exact Claim Amount, Contact details, e-mail Id etc.
2. Original cancel cheque copy or Passbook front page of the proposer (Mandatory) Complete bank details for RTGS / NEFT cancelled cheque
3. Photocopy of Gov. Recognized Photo ID proof (Aadhar Card / PAN Card of the Insured Patient/ Passport)
4. Original Discharge Card (In case of Day Care procedure to provide Day care Discharge summary). Hospital Discharge Certificate in original with Date & Time and details of treatment
5. All original investigation reports included Pre Hospital & Post hospital (If any). All the prescriptions, money receipt/cash memo, Investigation reports, hospital requisition and other supporting documents in original.
6. Hospital bill with detailed break up along with money Receipts in original .

7. All original Prescription of medicines & investigation which have been done attaching supportive advice of physician. In case of Implant- sticker & tax Invoice with money Receipt in original. (For Cataract, Patient lens identification card mandatory).
8. X-ray report with plate (Compulsory for fracture cases).
9. Indoor case papers (ICP)
10. Original Hospital bill (Pre-printed numbered bill).
11. Original pre-printed numbered Hospital bill payment receipt.
12. First Doctor Consultation paper and all previous treatment papers
13. MLC/FIR copy compulsory for accident cases.

In accidental cases self-statement/FIR/Medico legal report.

Other relevant documents pertaining to claim

For claiming Domiciliary

Provide the Domiciliary claim form, treating doctor's prescription, original bills for medicines and reports if any.

Please find the IRDAI claim form enclosed for your perusal.

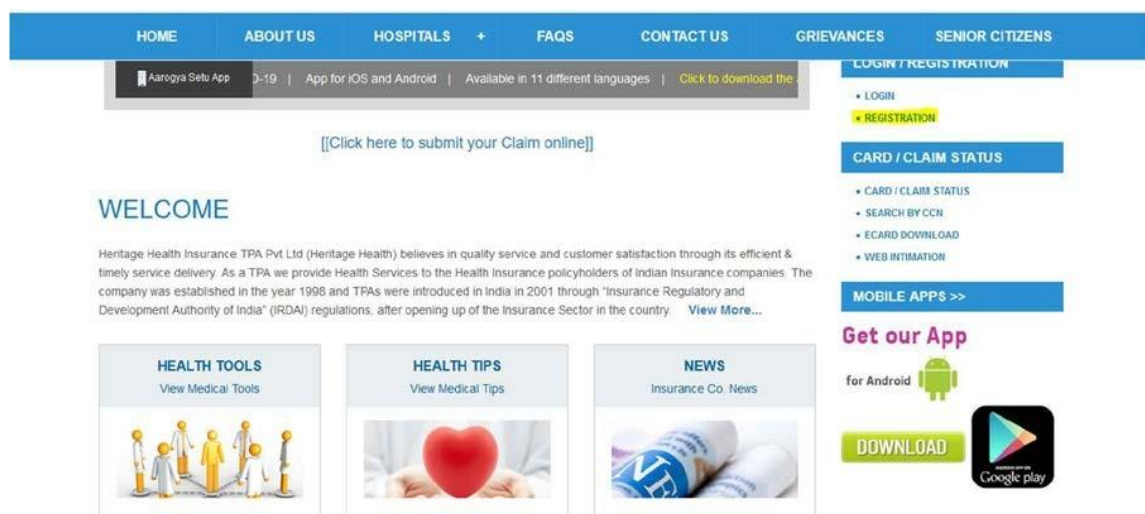


Screenshots for Ecard Generation

1. Go to our website : <http://www.heritagehealthtpa.com>



2. If you are not a registered user, please register from the option



3. Input your detail and register first.

Insurance Co. *	Indian Bank Association [In National Insurance Com] v
Bank Name *	Punjab National Bank v
First Name *	XXXXXXXXXX
Last Name *	XXXXXXXXXX
PolicyNumber	
CardNumber	
EmpID [For Corporate Employee only]	5143265
Email Address *	abc@xyz.com
Mobile NO	999999999
User Name *	TestUser
Password *	*****
Confirm Password *	*****

[Register](#) [Reset](#)

- ❑ Please note that, user ID is unique for any user.
- ❑ Password must be between 8-16 character with at least one Upper Case, one Lower case, one Special Character and One Numeric Character.
- ❑ Provided Email and Mobile no will be used for all further communication.
- ❑ Select Insurance Company Indian Bank Association [In National Insurance] and select your bank
- ❑ An email will be sent to your Email ID to verify the Email.

4. After registration, please use your UserName and Password to Login

[HOME](#) [ABOUT US](#) [HOSPITALS](#) + [FAQS](#) [CONTACT US](#) [GRIEVANCES](#) [SENIOR CITIZENS](#)

Login

User ID *

Password

[Forgot Password](#)

[Login](#) [Reset](#)

** If you are not a registered user, you can [Register Here...](#)

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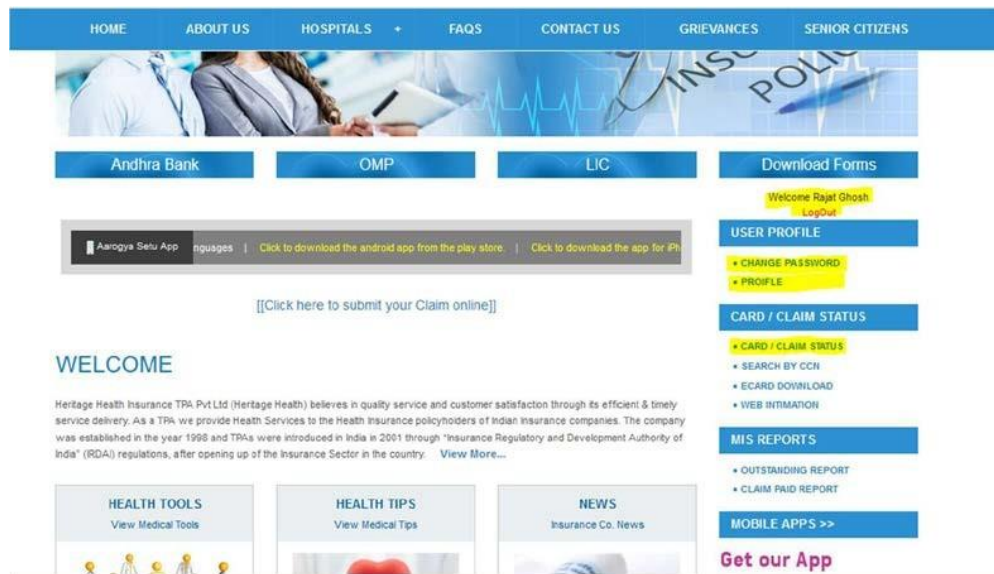
- ### 5. You can use the Forgot Password Option to change your Password after clicking the link, which will be sent to your registered Email ID

6. Once Logged in you can see various option like
 - a. Change Password
 - b. View Profile.
 - c. Card / Claim Status Check
 - d. Intimate your Claim
 - e. If you know your Unique CCN for any claim, you can use the option “Search By CCN” without logging In.
 - f. You can download your Ecard from the website, without Logging In, from the option “Download E Card”

DOWANLOAD E CARD

Insurance Co. *	Indian Bank Association [In National Insurance Coi ▼
CORPORATE NAME *	punja
Policy Year *	Punjab National Bank
EmpID *	5143265
Submit Reset	

7. You must be logged in to use the following option like CARD / CLAIM Status Search



The screenshot shows the Heritage Health Insurance website dashboard. At the top is a navigation bar with links: HOME, ABOUT US, HOSPITALS +, FAQs, CONTACT US, GRIEVANCES, and SENIOR CITIZENS. Below this is a banner image showing a doctor and a patient. Under the banner are buttons for Andhra Bank, OMP, LIC, and Download Forms. A welcome message for 'Rajat Ghosh' is displayed with a 'Logout' link. The main menu on the right includes: USER PROFILE (with links for CHANGE PASSWORD and PROFILE), CARD / CLAIM STATUS (with links for CARD / CLAIM STATUS, SEARCH BY CCN, ECARD DOWNLOAD, and WEB INTIMATION), MIS REPORTS (with links for OUTSTANDING REPORT and CLAIM PAID REPORT), and MOBILE APPS >>. The left sidebar contains sections for HEALTH TOOLS (View Medical Tools), HEALTH TIPS (View Medical Tips), and NEWS (Insurance Co. News). At the bottom, there is a 'Get our App' button.

HOME	ABOUT US	HOSPITALS	FAQS	CONTACT US	GRIEVANCES	SENIOR CITIZENS
Show 10 entries Page Content Search Box						
Sl	Photo/Card	Insured Particulars	Delivery Status	Return Status	E-Card Generation	#Claim
1	 TIA ID: HH51.070005946 Policy Validity: 01/10/2021 - 30/09/2022	Name: UDAY DHAYAN Relation: Self (Male) Sex: Male ENPID: 23631	Delivered: No Through: N/A	Returned: No	Download All Ecard_Details	
2	 TIA ID: HH51.070005947 Policy Validity: 01/10/2021 - 30/09/2022	Name: MOHIT DHAYAN Relation: Son Sex: Male ENPID: 23631	Delivered: No Through: N/A	Returned: No	Ecard_Details	
3	 TIA ID: HH51.070005948 Policy Validity: 01/10/2021 - 30/09/2022	Name: ANSHUL DHAYAN Relation: Daughter Sex: Female ENPID: 23631	Delivered: No Through: N/A	Returned: No	Ecard_Details	
4	 TIA ID: HH51.070005949 Policy Validity: 01/10/2021 - 30/09/2022	Name: POORAM DHAYAN Relation: Wife Sex: Female ENPID: 23631	Delivered: No Through: N/A	Returned: No	Ecard_Details	
5	 TIA ID: HH51.070005950 Policy Validity: 01/10/2021 - 30/09/2022	Name: KAMLESH DHAYAN Relation: Brother Sex: Female ENPID: 23631	Delivered: No Through: N/A	Returned: No	Ecard_Details	
Sl	Photo/Card	Insured Particulars	Delivery Status	Return Status	E-Card Generation	#Claim

Showing 1 to 5 of 5 entries

Previous 1 Next

Click Download All for Ecard of All Member or you can download Ecard for each member.



ID Number :HH51.0701381135
Name Of Insured :AMIT KUMAR DAS
Name Of Employee :AMIT KUMAR DAS
Emp No. :5143265
RELATION :Self (Male)
AGE :39



This Card is for identification for Mediclaim Purpose only

24 hours help line (Toll free) : 1800 102 4547
Contact Number for general and claim enquiries : 033-40334141

Website : www.heritagehealthtpa.com

Terms and Conditions

1. This card is for identification purpose only and not an authorization to proceed with treatment or a guarantee for payment.
2. Pre authorization is compulsory from TPA prior to a planned admission and within 24 hours for emergencies in network hospitals.
3. All preauthorization and/or settlement of claims is subject to the terms and conditions of the policy.



HERITAGE HEALTH INSURANCE TPA PVT. LTD.
NICCO HOUSE, 5th Floor, 2 Hare Street, Kolkata - 700 001
IRDAI License no. : 008, CIN : U05195WB1998PTC08562





Screenshots for Claim Details

1. You can view the claim Details by Clicking the Claim Details Option.

HERITAGE HEALTH INSURANCE TPA PVT. LTD.
IRDAI license No 008(Valid Till 20/03/2023) CIN U85195WB1998PTC088562 An ISO 9001:2015 Company

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Show 10 entries Search:

Sl	Insured Particulars	Claim Particulars	Hospital Particulars	CLAIM STATUS	DOCUMENT VIEW
1	Insured Name : Shri Ritesh Kumar Card No : HHS1.0700605869 Claim Amount : 341200.00	CCN : HH172242875 Intimation Date : 01/10/2021 Claim Type : Cash Less Bill Type : Bill Not Entered	Date Of Admission : 02/10/2021 Date Of Discharge : 05/10/2021 Illness : GRADE III HAEMORRHOIDS	Claim_Details	Claim_Documents

Showing 1 to 1 of 1 entries Previous 1 Next

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- INSURED DETAILS
- CLAIM DETAILS
- QUERY DETAILS
- PRE AUTHORIZATION DETAILS

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INSURED DETAILS

INSUREDNAME :	RAJLAKSHMI DAS	POLICY NUMBER :	251100502210000185
CARD NO :	HHS1.0701381138	AGE :	61
ORGANISATION :	Punjab National Bank	RELATION :	Mother
Head Of The Family :	AMIT KUMAR DAS	Card Number Of Head Of The Family :	HHS1.0701381135

CLAIM DETAILS

CCN :	HH172377327	CLAIMTYPE :	Reimbursement
HOSPITAL NAME :	Apollo Gleneagles Hospitals Ltd.	HOSPITALCITY :	KOLKATA
DOA :	01/10/2022	DOD :	06/10/2022
INTIMATION DATE :	01/10/2022	DOCUMENT RECEIVED DATE :	08/11/2022
CLAIM STATUS :	Claim is in process	SETTLE AMOUNT :	
SETTLEMENT DATE :		CLOSED/REJECT DATE :	
PROVISIONAL REJECT DATE :		TRANSFER AMOUNT :	
TRANSFER DATE :		UTR NO :	

QUERY DETAILS

2. Intimate Your claim by using the Option Web Intimation

HOME

ABOUT US

HOSPITALS +

FAQS

CONTACT US

GRIEVANCES

SENIOR CITIZENS

INTIMATE CLAIM

Insurance Co. *

--Select Insurance Company--

Policy Number

Card Number

EmpID

625191

Policy Year *

2021 - 2022

SubmitReset

Welcome Ms. Shilpa Sharma Sarkar
[LogOut](#)

USER PROFILE

CHANGE PASSWORD

PROFILE

CARD / CLAIM STATUS

CARD / CLAIM STATUS

SEARCH BY CCI

E CARD DOWNLOAD

WEB INTIMATION

MIS REPORTS

OUTSTANDING REPORT

CLAIM PAID REPORT

MOBILE APPS >>

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GRIEVANCES

SENIOR CITIZENS

SHOW TO

SEARCH

Sl	Photo/Card	Insured Particulars	Delivery Status	Return Status	Add WebIntimation	View Intimation
1	 TPA ID : HHS1.0700605869 Policy Validity : 01/10/2021 - 30/09/2022	Name : Shri Ritesh Kumar Relation : Self (Male) Sex : Male EMPID : 625191	Delivered : No Through : N/A	Returned : No	Add Web Intimation 	
2	 TPA ID : HHS1.0700605870 Policy Validity : 01/10/2021 - 30/09/2022	Name : Purnendu Choudhary Relation : Father Sex : Male EMPID : 625191	Delivered : No Through : N/A	Returned : No	Add Web Intimation 	
3	 TPA ID : HHS1.0700605871 Policy Validity : 01/10/2021 - 30/09/2022	Name : URMILA DEVI Relation : Mother Sex : Female EMPID : 625191	Delivered : No Through : N/A	Returned : No	Add Web Intimation 	
4	 TPA ID : HHS1.0700605872 Policy Validity : 01/10/2021 - 30/09/2022	Name : Juhi Kumari Relation : Wife Sex : Female EMPID : 625191	Delivered : No Through : N/A	Returned : No	Add Web Intimation 	

HOME

ABOUT US

HOSPITALS +

FAQS

CONTACT US

GRIEVANCES

SENIOR CITIZENS

WEB INTIMATION

-; Lodge Claim :-

* Fields are mandatory

Contact/Mobile *	
Email Address *	
Describe Illness/Probable Diagnosis	
Date of Admission *	
Date of Discharge *	
Amount Estimated [Rs.] *	
Remarks	
Select Hospital *	
Hospital Name *	

USER PROFILE

- CHANGE PASSWORD
- PROFILE

CARD / CLAIM STATUS

- CARD / CLAIM STATUS
- SEARCH BY CCN
- ECARD DOWNLOAD
- WEB INTIMATION

MIS REPORTS

- OUTSTANDING REPORT
- CLAIM PAID REPORT

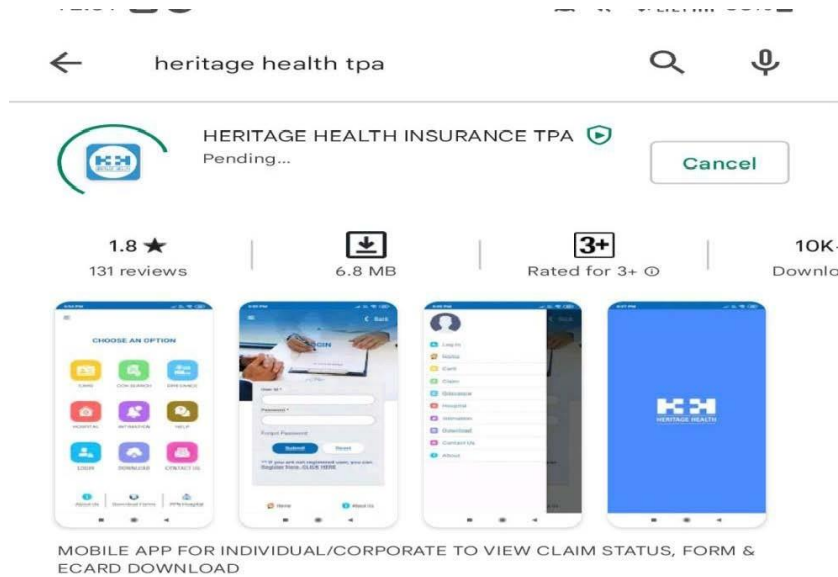
MOBILE APPS >>

Get our App

DOWNLOAD

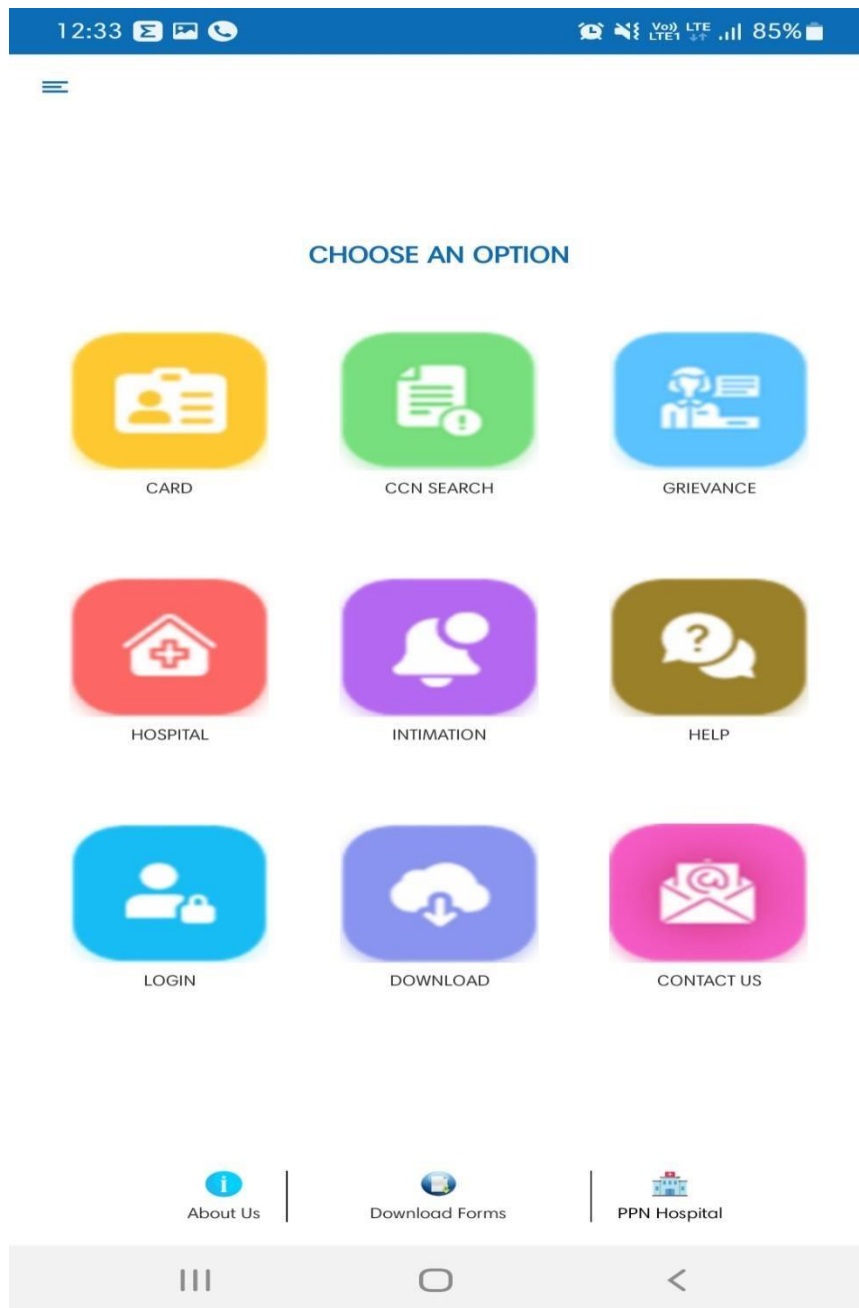


Slide.1 - Download Heritage Mobile application from playstore for anroid mobile

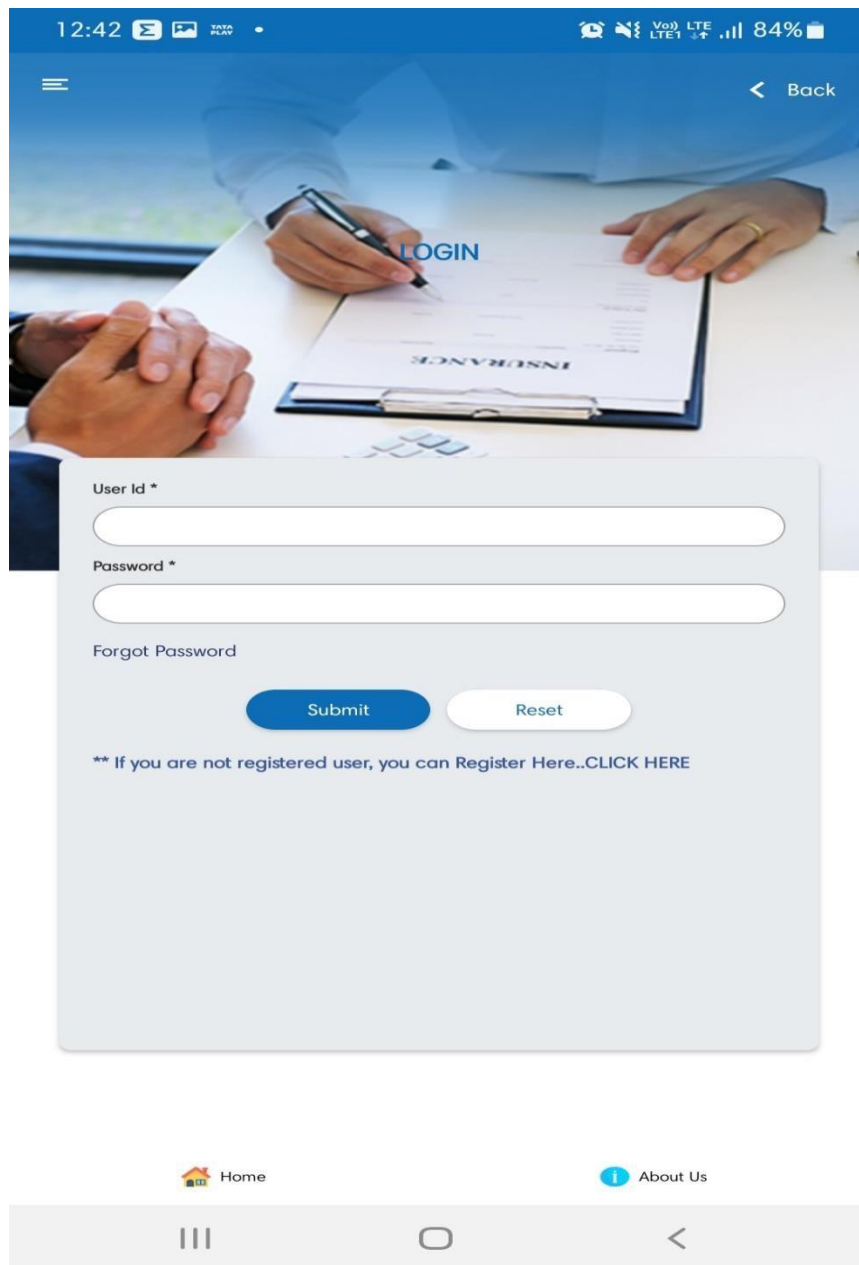


MOBILE APP FOR INDIVIDUAL/CORPORATE TO VIEW CLAIM STATUS, FORM & ECARD DOWNLOAD

Slide.2 - Home screen of the Heritage application



Slide.3 - First page for registration



12:42 5 TOTAL 84%

LOGIN

Back

User Id *

Password *

Forgot Password

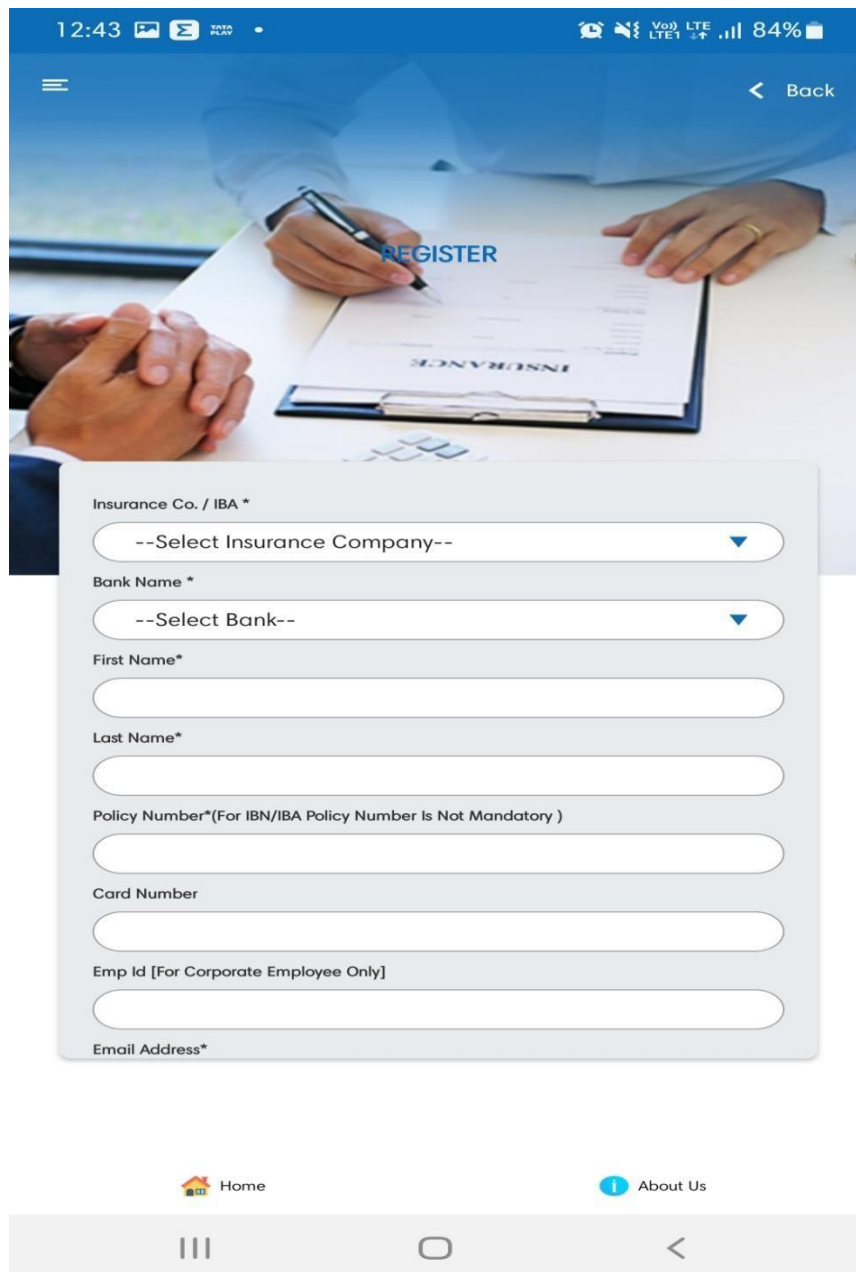
Submit Reset

** If you are not registered user, you can Register Here..CLICK HERE

Home About Us

III O <

Slide.4 - Fill up details for registration



The image shows a mobile application interface for registration. The background is a photograph of a person's hands signing a document labeled 'INSURANCE' on a clipboard. The app's status bar at the top shows the time as 12:43, battery at 84%, and LTE signal. The app's header has a blue background with a menu icon on the left and a 'Back' button on the right. A large blue 'REGISTER' button is centered over the background image. Below this, a light gray registration form is displayed. The form contains several fields: 'Insurance Co. / IBA *' with a dropdown menu showing '--Select Insurance Company--'; 'Bank Name *' with a dropdown menu showing '--Select Bank--'; 'First Name*' with a text input field; 'Last Name*' with a text input field; 'Policy Number*(For IBN/IBA Policy Number Is Not Mandatory)' with a text input field; 'Card Number' with a text input field; 'Emp Id [For Corporate Employee Only]' with a text input field; and 'Email Address*' with a text input field. At the bottom of the screen, there is a navigation bar with two icons: a house icon labeled 'Home' and an information icon labeled 'About Us'. Below the navigation bar is a standard Android navigation bar with three icons: a square, a circle, and a triangle.

12:43 84% LTE

REGISTER

Insurance Co. / IBA *

--Select Insurance Company--

Bank Name *

--Select Bank--

First Name*

Last Name*

Policy Number*(For IBN/IBA Policy Number Is Not Mandatory)

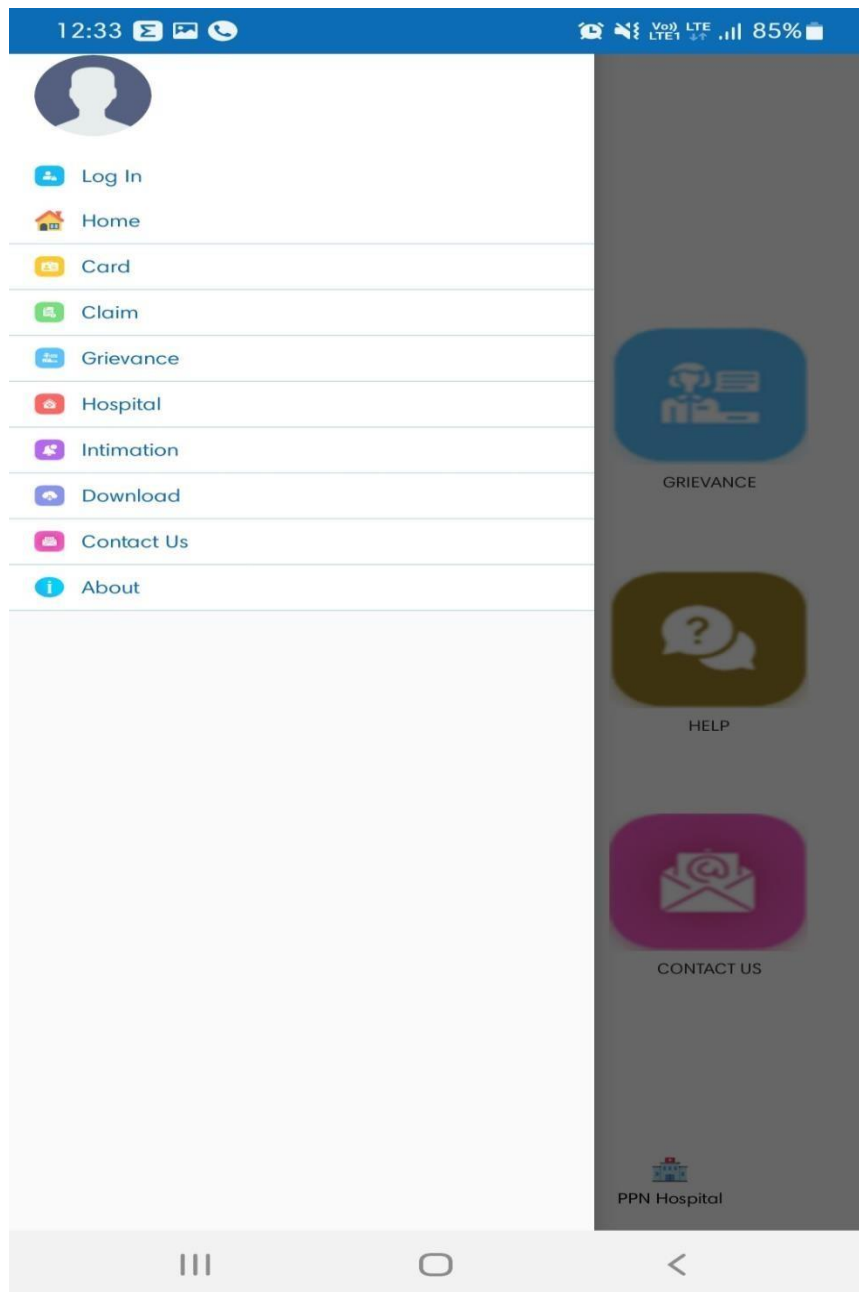
Card Number

Emp Id [For Corporate Employee Only]

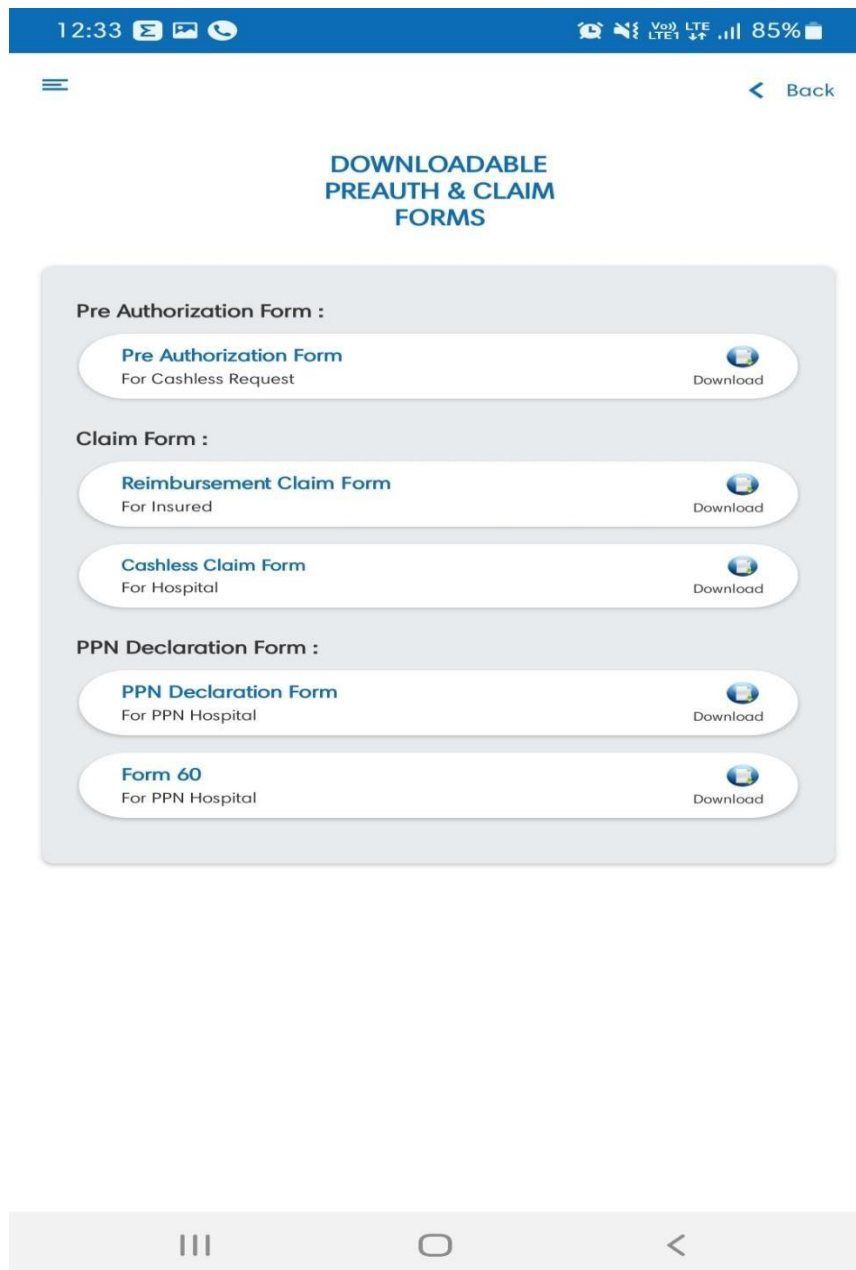
Email Address*

Home About Us

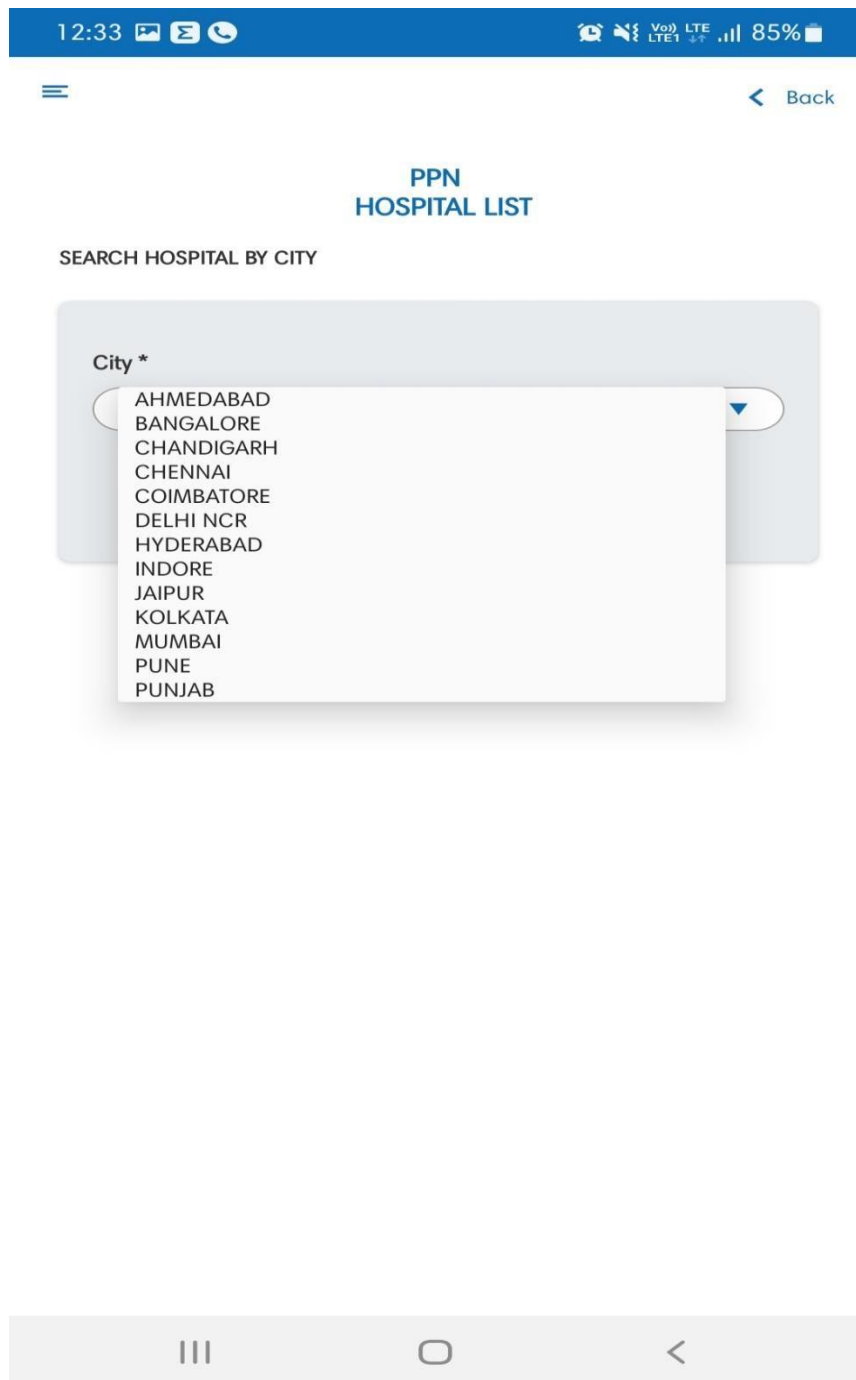
Slide.5 - Drawer menu



Slide.6 - Dowload Preauth & Claim forms



Slide.7 - Search PPN Hospital Name with City wise



Slide.8 - For empanelled Hospital List

12:40

  VoLTE

 85%

  Back

EMPANELLED HOSPITAL LIST

SEARCH HOSPITAL BY CITY

State *

--Select State--

City *

Insurance Co *

--Select Insurance Company--

Submit

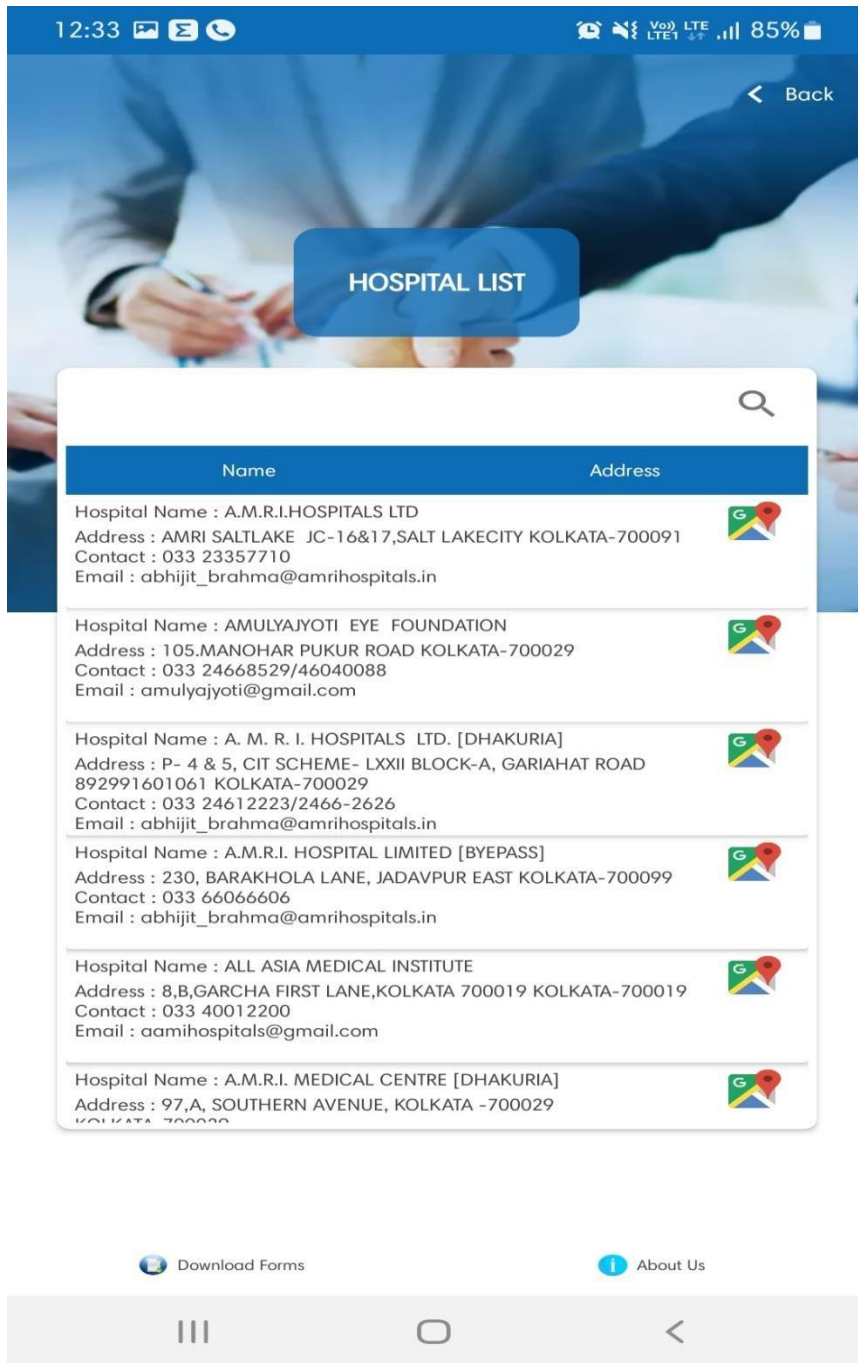
Reset

III

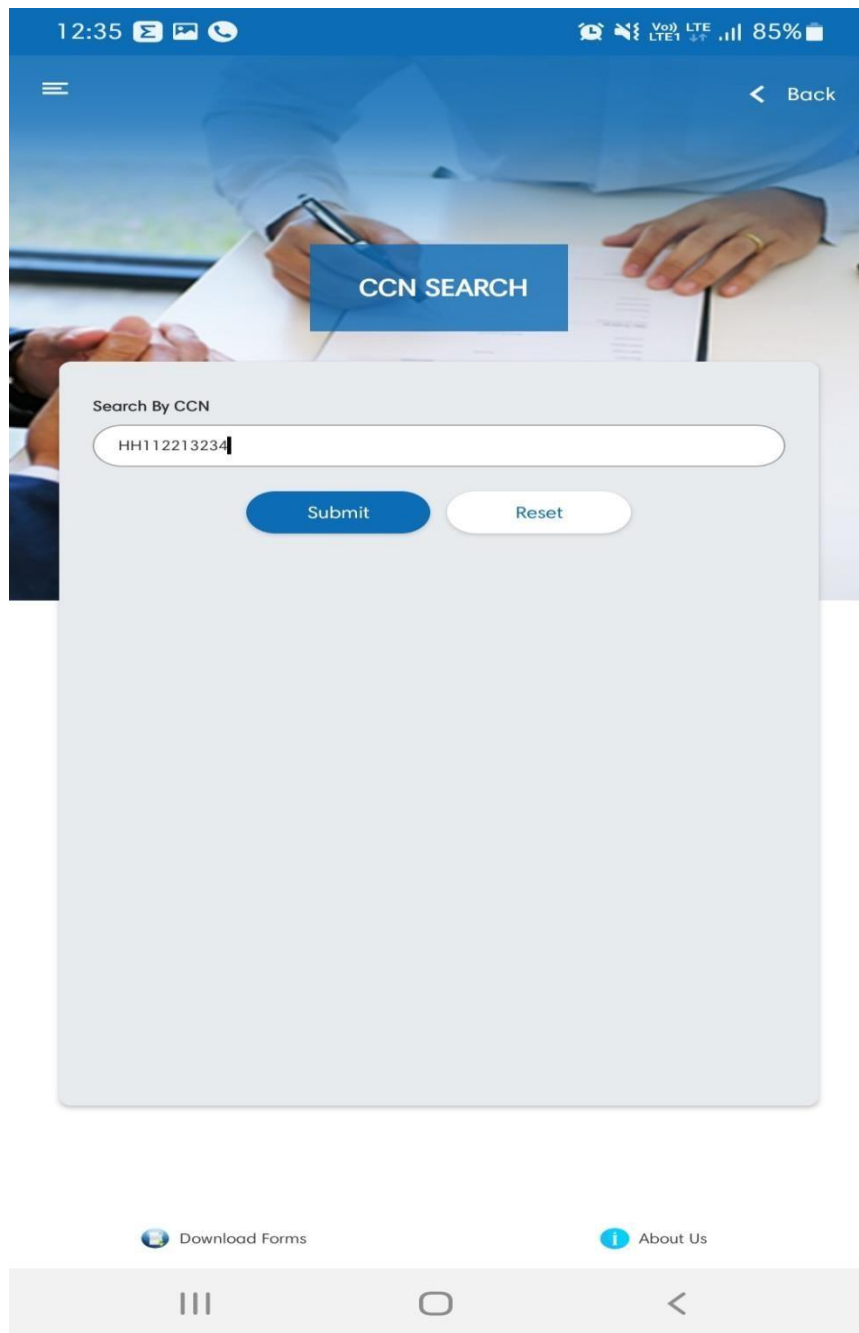
O

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Slide.9 - List of Hospital with location map



Slide.10 - Search claim with Claim number (CCN)



The image shows a mobile application interface for searching claims by Claim Number (CCN). The app is running on an Android device, as indicated by the status bar at the top showing the time 12:35, battery level at 85%, and LTE signal. The main screen features a blue header with a menu icon on the left and a 'Back' button on the right. A large blue button labeled 'CCN SEARCH' is centered on the screen. Below this, a modal dialog box is open, titled 'Search By CCN'. It contains a text input field with the value 'HH112213234' and two buttons: 'Submit' and 'Reset'. At the bottom of the app, there is a navigation bar with two links: 'Download Forms' and 'About Us'. The background of the app shows a blurred image of hands holding a pen over a document.

12:35 85% LTE

CCN SEARCH

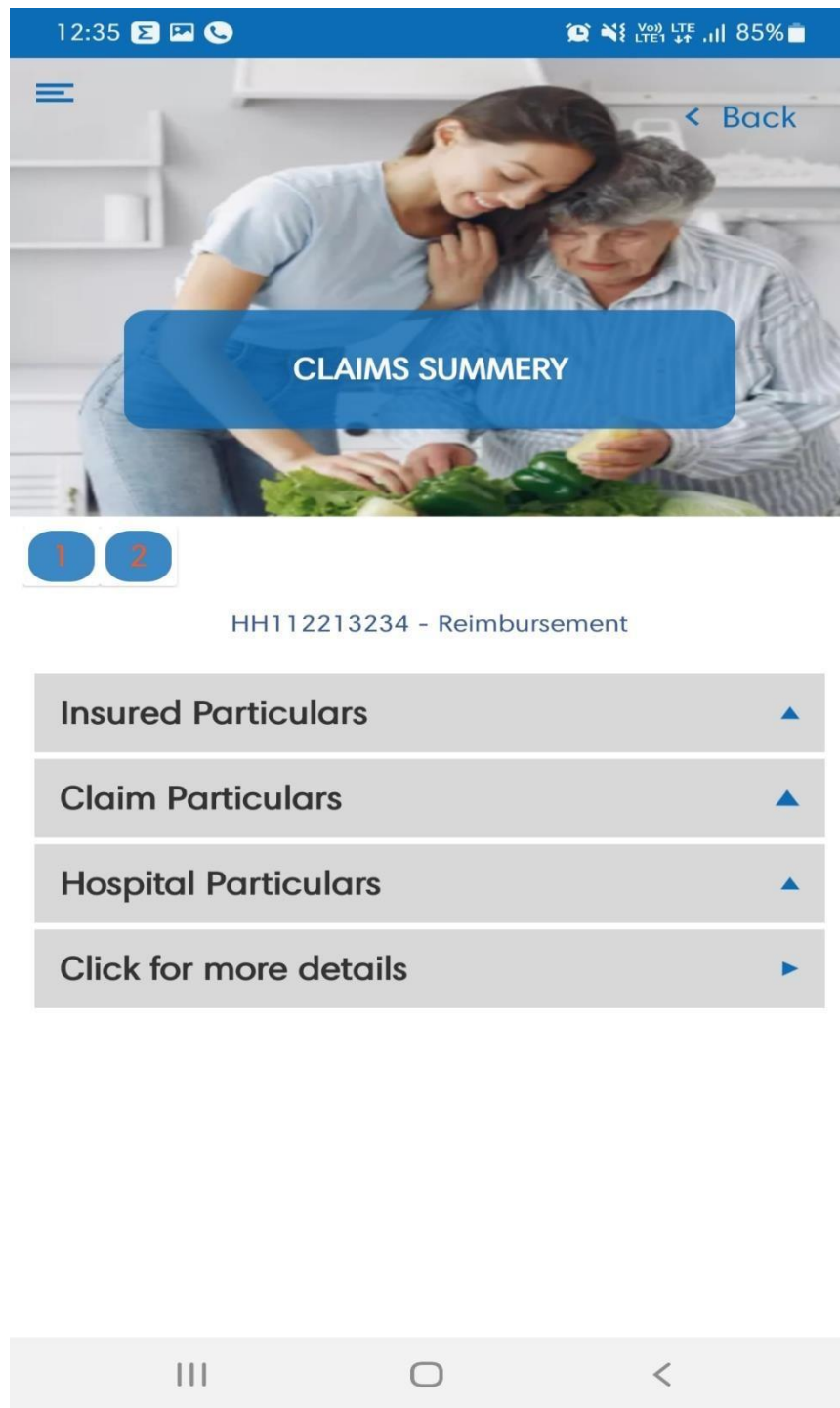
Search By CCN

HH112213234

Submit Reset

Download Forms About Us

Slide.11 - Claims summary



Slide.12 - Click on arrow icon for more details (Main Claim in Page1)

12:35



 Back



CLAIMS SUMMERY

1

2

HH112213234 - Reimbursement

Insured Particulars

INSURED NAME : VASUNDHARA SHROFF
CARD NUMBER : HHS1.0146486824
CLAIM AMOUNT : 459335.00

Claim Particulars

CCN: HH112213234
INTIMATION DATE : 11/03/2022
CLAIM TYPE : Reimbursement
BILL TYPE : Main Bill

Hospital Particulars

DATE OF ADMISSION : 16/02/2022
DATE OF DISCHARGE : 21/02/2022

12:35

Vol LTE

LTE

85%

Back

CLAIMS SUMMERY

1

2

HH112213234 - Reimbursement Sub Bill

Insured Particulars

INSURED NAME : VASUNDHARA SHROFF
CARD NUMBER : HHS1.0146486824
CLAIM AMOUNT : 104300.00

Claim Particulars

CCN: HH112213234
INTIMATION DATE : 11/03/2022
CLAIM TYPE : Reimbursement Sub Bill
BILL TYPE : Main Bill

Hospital Particulars

DATE OF ADMISSION : 16/02/2022
DATE OF DISCHARGE : 21/02/2022

Slide.14 - Claim details

12:35



VoLTE LTE 85%

 Back



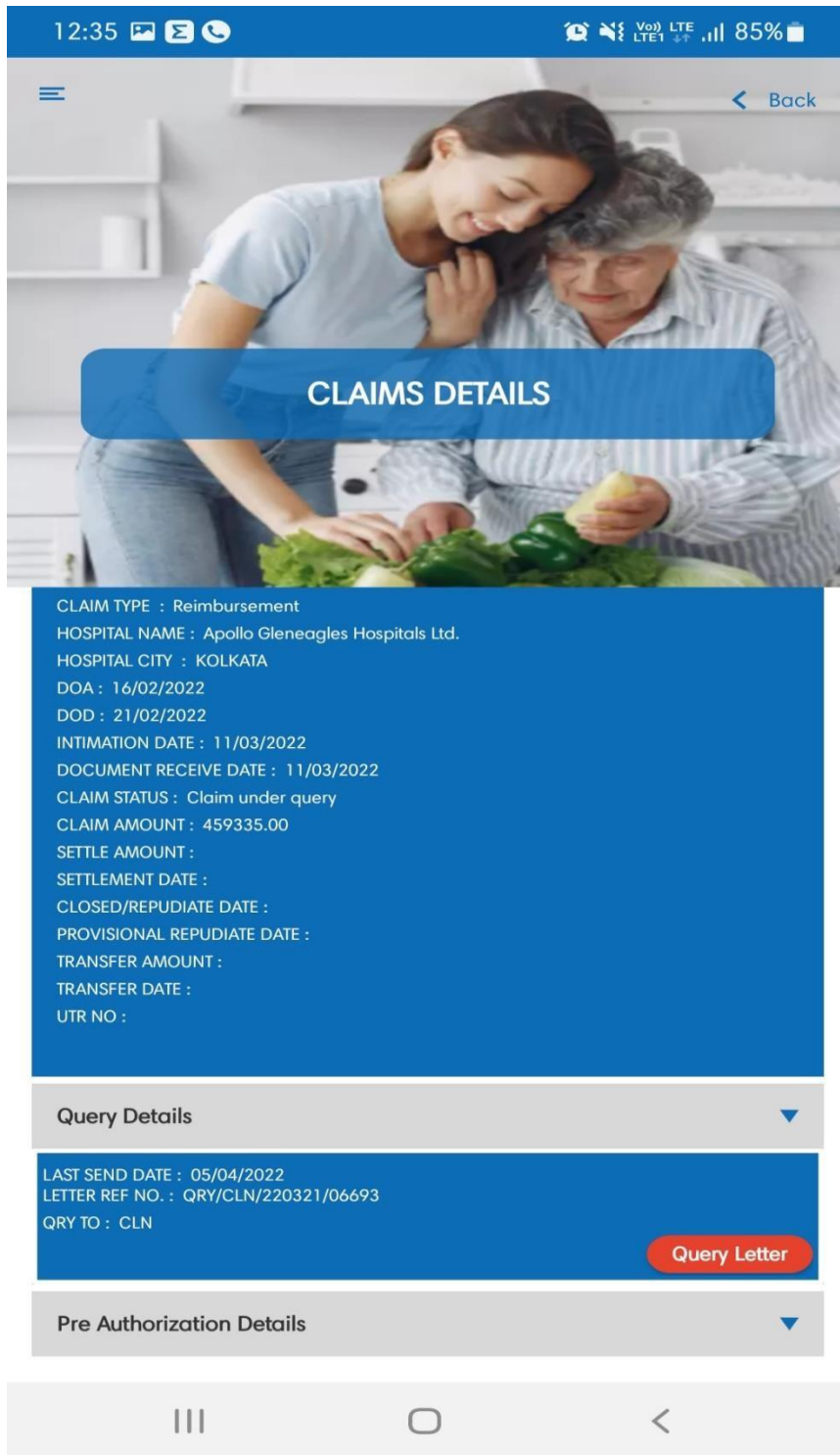
CLAIMS DETAILS

Insured Details

INSURED NAME : VASUNDHARA SHROFF
POLICY NUMBER : 100900502110010411
CARD NUMBER : HHS1.0146486824
AGE : 45
ORGANISATION :
RELATION : Wife
Head of The Family : YASHWANT SHROFF
Head of The Card Number : HHS1.0146486823

Claim Details

CCN : HH112213234
CLAIM TYPE : Reimbursement
HOSPITAL NAME : Apollo Gleneagles Hospitals Ltd.
HOSPITAL CITY : KOLKATA
DOA : 16/02/2022
DOD : 21/02/2022
INTIMATION DATE : 11/03/2022
DOCUMENT RECEIVE DATE : 11/03/2022
CLAIM STATUS : Claim under query
CLAIM AMOUNT : 459335.00
SETTLE AMOUNT :
SETTLEMENT DATE :
CLOSED/REPUDIATE DATE :



Slide.16 - For download E-card and Insured details against particular policy details

12:37 12:37 85%

Back

CARD / CLAIM STATUS

Insurance Co. *

National Insurance

Policy Number

100900502110010411

Card Number

EmpId

Policy Year *

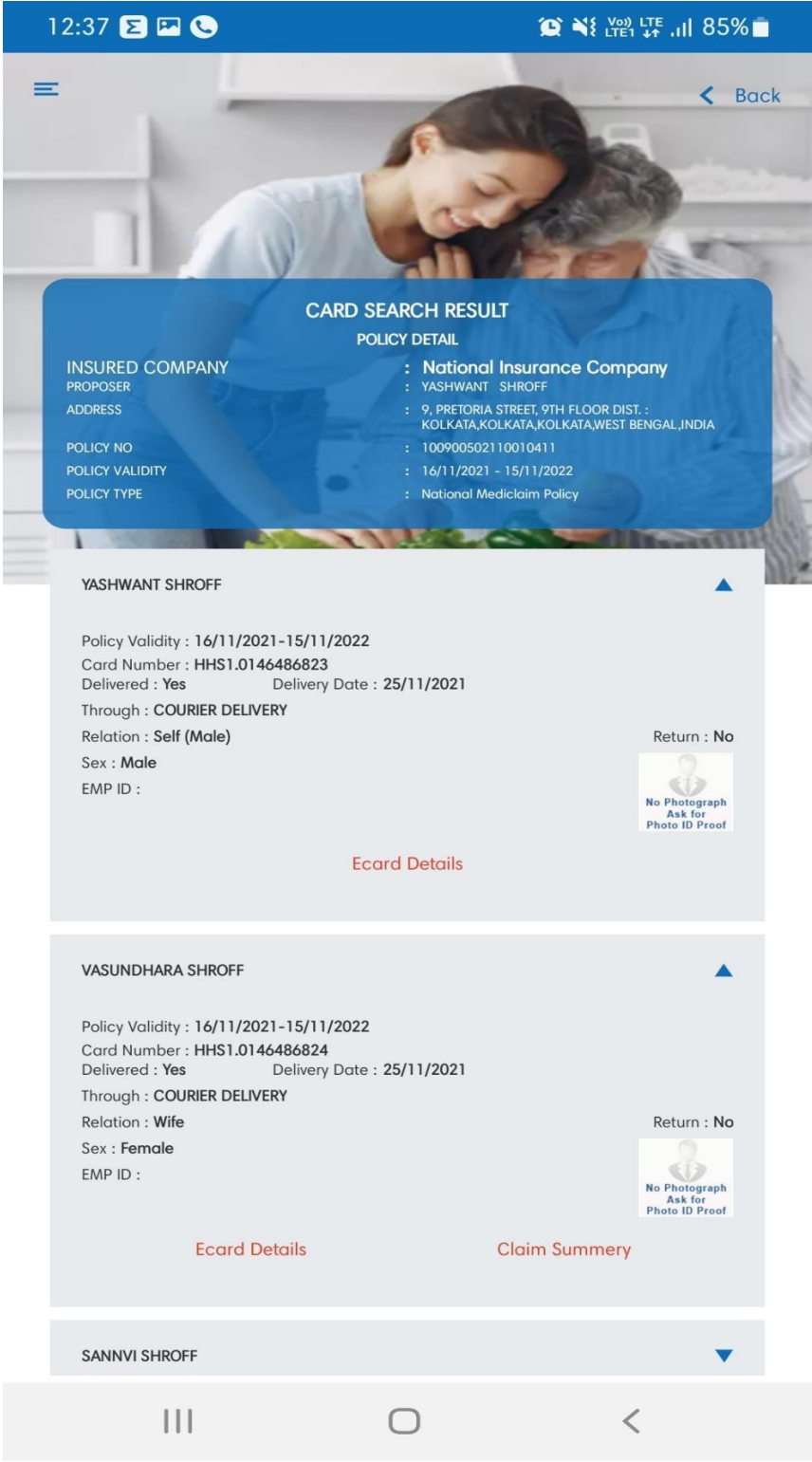
Select Year

** Policy year is mandatory for search by Card No. or Emp Id and not mandatory for search by Policy No.

Submit Reset

Download Forms About Us

Slide.18





Name : YASHWANT SHROFF
AGE : 44 SEX : MALE
RELATION : Self (Male)
POLICYNUMBER : 100900502110010411
NATIONAL MEDICLAIM POLICY
ID : HHS1.0146486823
VALIDITY : 16/11/2021-15/11/2022
PROPOSER : YASHWANT SHROFF



This Card is for Identification for Mediclaim Purpose only

24 hours help line (Toll free) : 1800 102 4547

Contact number for general and claim enquiries : 033-40334141

Website : www.heritagehealthtpa.com

Terms and Conditions

1. This card is for identification purpose only and not an authorization to proceed with treatment or a guarantee for payment.
2. Pre authorization is compulsory from TPA prior to a planned admission and within 24 hours for emergencies in network hospitals.
3. All preauthorization and/or settlement of claims is subject to the terms and conditions of the policy.



HERITAGE HEALTH INSURANCE TPA PVT. LTD.
"Nicco House" 5th Floor, 2 Hare Street, Kolkata - 700 001
IRDAI License no. : 006, CIN : U85195WB1998PTC088562



Slide.20 - For lodge grievance if any

12:40

DATA PLAY

VoLTE1 LTE1 85%

Back

LODGE GRIEVANCE

Empld [For corporate employee only]

Insurance Co *

--Select Insurance Company--

Policy Number

Card Number

Claim Number

Contact Number *

Email Address *

Before Grievance *

SubmitReset

III

O

<

Slide.21 - For lodge Claim intimation

12:41

VoLTE 84%

WEB INTIMATION

Contact/Mobile *

9062080728

Email Address *

pagalpritt@gmail.com

Describe Illness/Probable Diagnosis *

Test

Date of Admission *

8/4/2022

Probable date of discharge

Amount Estimated [Rs.] *

10000

Remarks *

Test

Submit

Reset

Download Forms

About Us

12:42

84%

Back

WEB INTIMATION

Choose your hospital

West Bengal

KOLKATA

Submit

SL	Name	Address
	Hospital Name : A.M.R.I.HOSPITALS LTD	
	Address : AMRI SALT LAKE JC-16&17, SALT LAKE CITY KOLKATA-700091	
	Contact : 033 23357710	
	Email : abhijit_brahma@amrihospitals.in	
	Hospital Name : AMULYAJYOTI EYE FOUNDATION	
	Address : 105.MANO HAR PUKUR ROAD KOLKATA-700029	
	Contact : 033 24668529/46040088	
	Email : amulyajyoti@gmail.com	
	Hospital Name : A. M. R. I. HOSPITALS LTD. [DHAKURIA]	
	Address : P- 4 & 5, CIT SCHEME- LXXII BLOCK-A, GARIAHAT ROAD 892991601061 KOLKATA-700029	
	Contact : 033 24612223/2466-2626	
	Email : abhijit_brahma@amrihospitals.in	
	Hospital Name : A.M.R.I. HOSPITAL LIMITED [BYEPASS]	
	Address : 230, BARAKHOLA LANE, JADAVPUR EAST	

Download Forms

About Us

12:42

84%

  Back

FREQUENTLY ASKED QUESTIONS

What is a TPA?

"TPA" means a Third Party Administrator who is licensed by the IRDAI, for the purpose of providing services to the "Health Insurance – Policyholders" under an agreement with an insurance company.

What are the services offered by Heritage?

Services offered by Heritage may be broadly grouped as:
Issuance of Cards & Guidebook.
Cash Less Access Service.
Settlement of Reimbursement Claim.
Call Centre Services.

Is HERITAGE HEALTH INSURANCE TPA PVT. LTD. - a Licensed TPA?

HERITAGE HEALTH INSURANCE TPA PVT. LTD. is an IRDAI - Licensed TPA. Our License Number is 008.

Why Cards & Guidebook are issued?

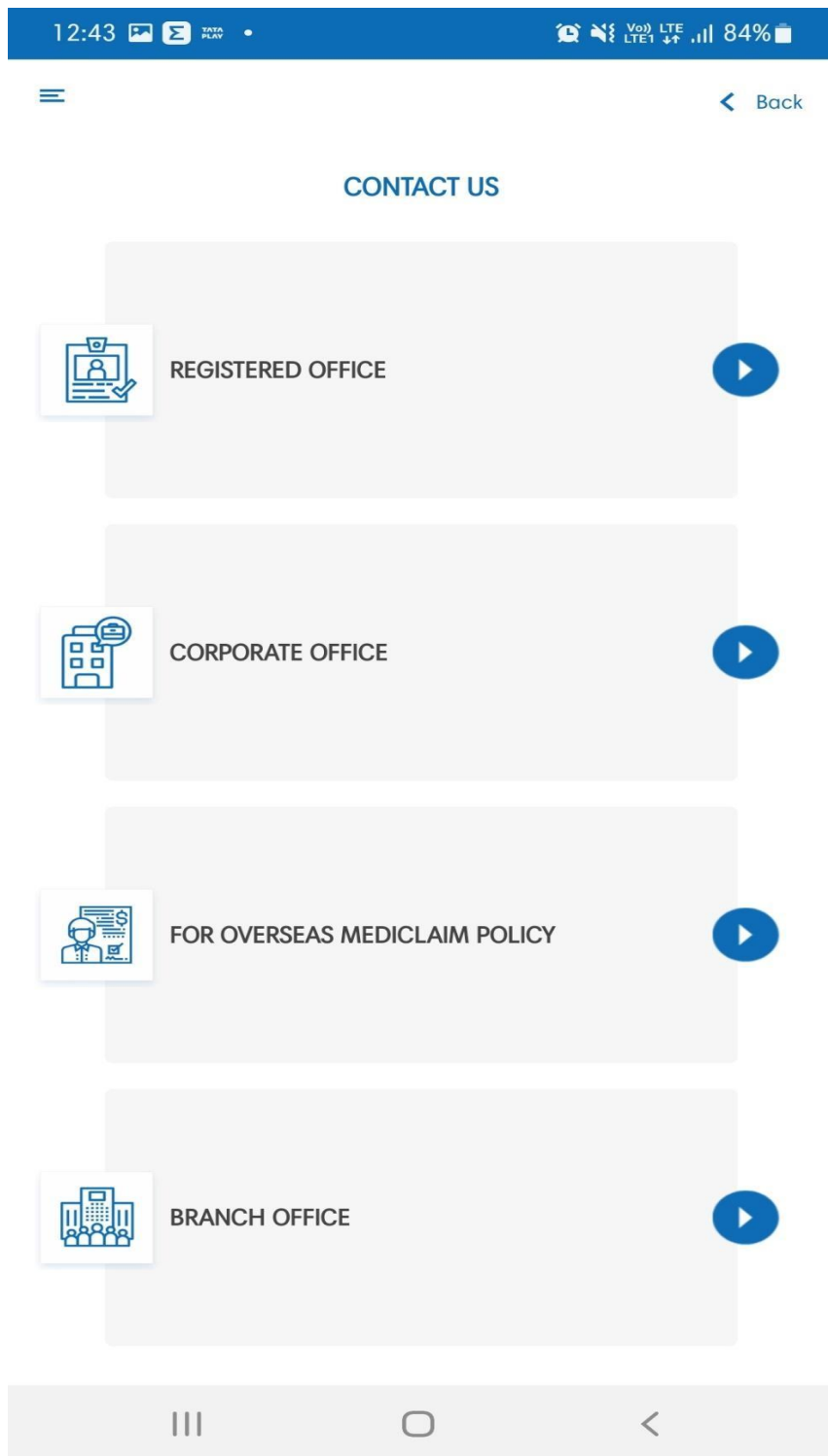
The Cards are issued by Heritage to each Insured for Identification purpose. Each Card has a unique identification number, which is to be mentioned during communication with Heritage. It also carries the Policy No, Name of the relevant Insurance Company, Age, Photograph and Phone/Fax No. of Heritage. Cards are produced to the Network Hospital at the time of applying for Cash Less. Guide Book contains the list of Network Hospitals and Procedure to be followed for lodging Claims / Cash Less. Prescribed Format for the same is also given.

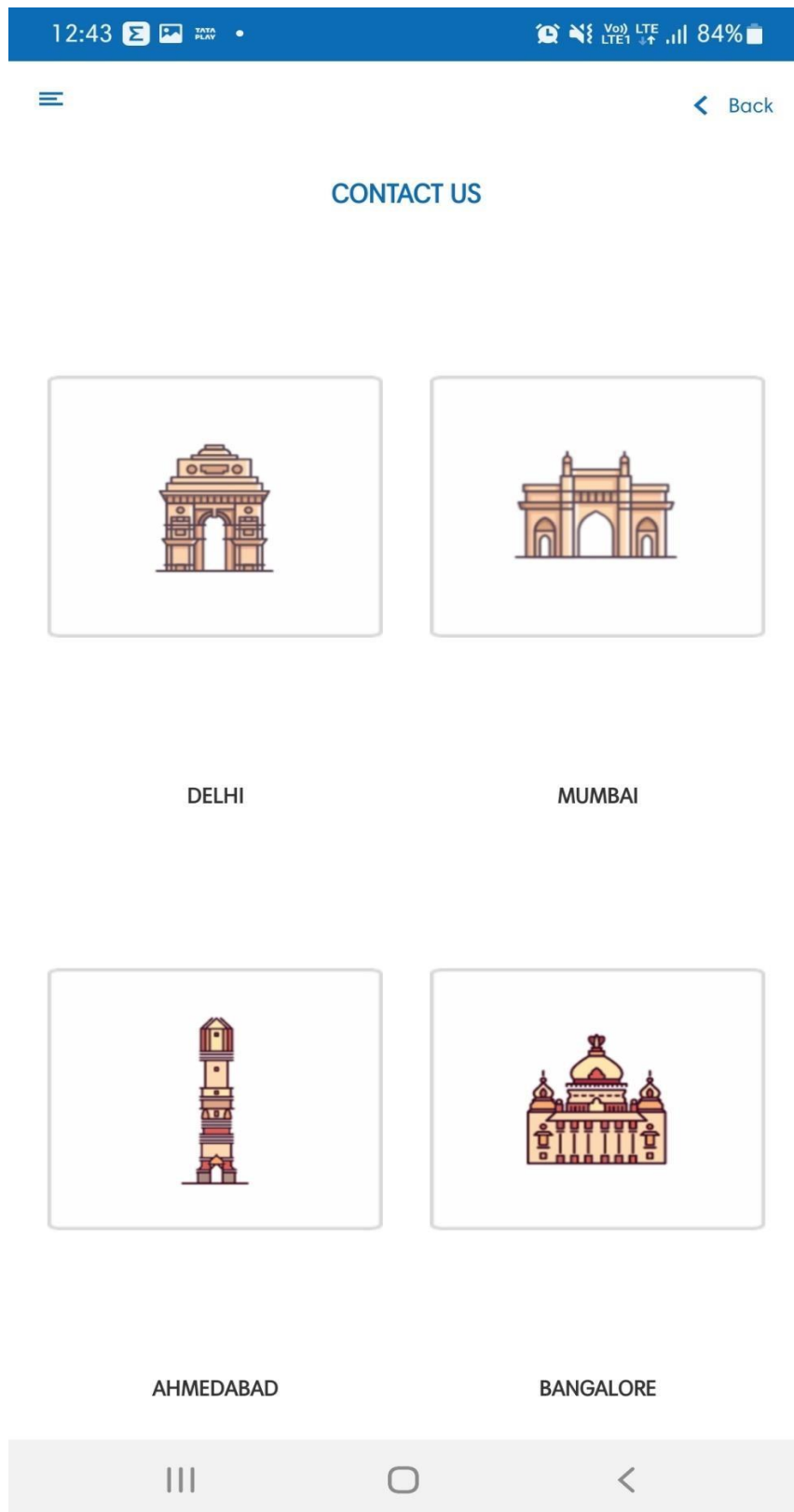
What is Cash Less Access Benefit?

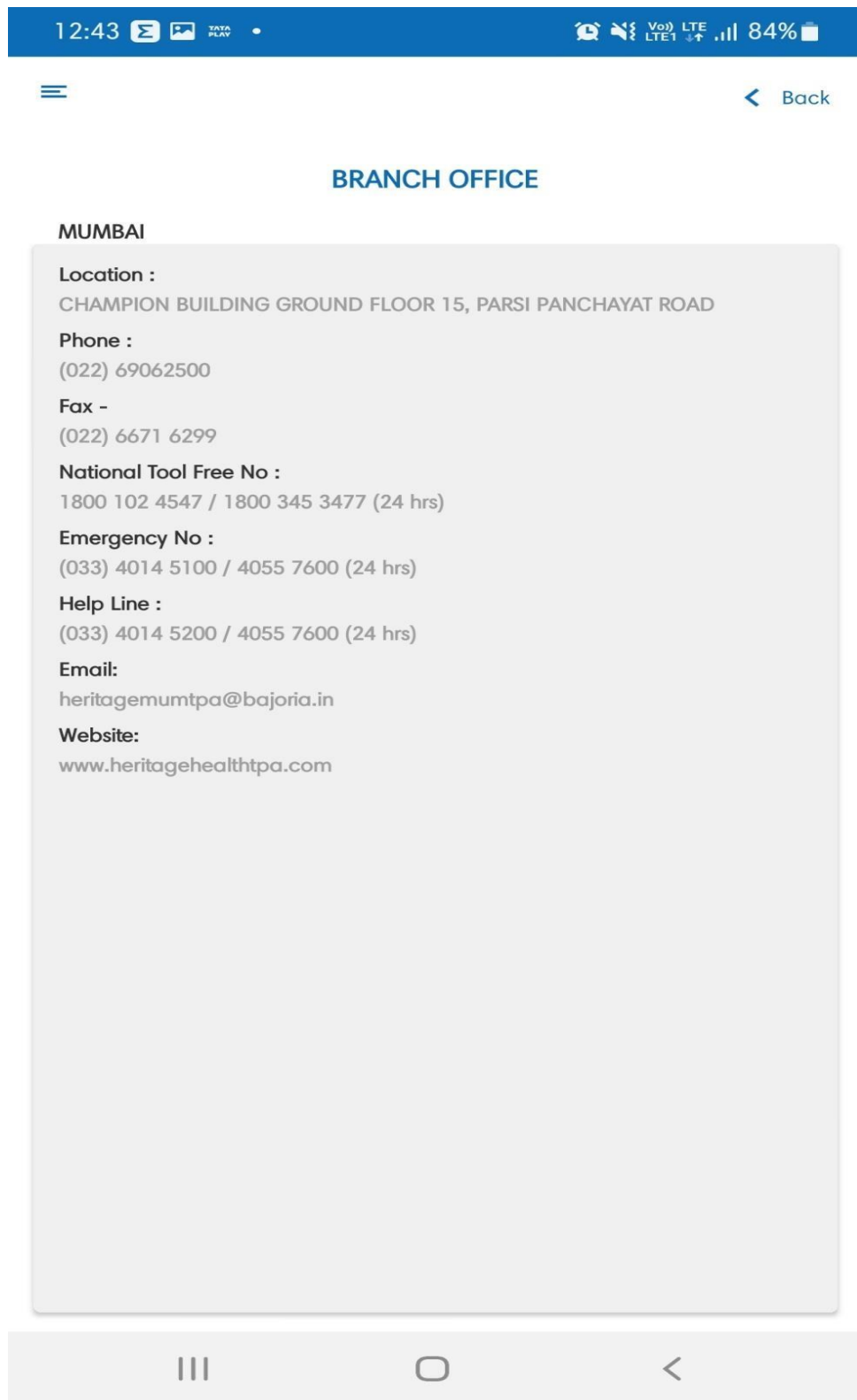
One of the main features of TPA is extending Cash Less Access Benefit. If Cash Less facility is availed by an Insured, he/she needs not to pay any Deposit money at the time of Admission into a Network Hospital. The Insured gets quality treatment without paying for the treatment expenditure from his pocket. The Cash Less benefit reduces this financial burden and helps you recover with peace of mind. The Cash less service is



Slide.24 - Contact us







LIST OF CIRCLE WISE CONTACT DETAILS OF HR OFFICIALS

Name of Circle Offices	Related Zonal office	Name of Contact Person	Mobile no	Email ID
ALIGARH	AGRA	Shweta Siddharth	9654198190	coali_hrd@pnb.co.in
AGRA	AGRA	MR. ARPIT SHARMA	7500049934	coagrhrd@pnb.co.in
BAREILLY	AGRA	MR. SATYAM DIXIT	8800945348	cobarhrd@pnb.co.in
BULANDSHAHR	AGRA	MR. VAIVAH AGARWAL	8171163131	cobshrhd@pnb.co.in
ETAWAH	AGRA	MR. UATTPAL YADAV	9450797497	coetawhrd@pnb.co.in
JHANSI	AGRA	Mr. Purneet saini	7233803057	coburhrd@pnb.co.in
AHMEDABAD	AHMEDABAD	Laxmi Madam	9870437700	coahmhrd@pnb.co.in
RAJKOT	AHMEDABAD	Mr. Jatin	7347449891	corajhrd@pnb.co.in
SURAT	AHMEDABAD	Nalini	7574939993	cosurathrd@pnb.co.in
VADODARA	AHMEDABAD	Sarika Patel	8989996914	covadhrd@pnb.co.in
AMRITSAR	AMRITSAR	MR. ANMOL	9389844546	coasrhrd@pnb.co.in
HOSHIARPUR	AMRITSAR	MS. ISHITA	9870363997	cohshphrd@pnb.co.in
JALANDHAR	AMRITSAR	MR. DEEPAK KUMAR	9814848613	cojalhrd@pnb.co.in
JAMMU	AMRITSAR	MR. ISHAN SHARMA	9858118567	cojkhrrd@pnb.co.in
KAPURTHALA	AMRITSAR	MS. SEEMA BHATTA	8699586926	cokpthrd@pnb.co.in
PATHANKOT	AMRITSAR	MR. VIKRAM SINGH	9464757576	copathanhrd@pnb.co.in
SRINAGAR	AMRITSAR	MR. ROHIT KUNDAL	8580715371	cosgrhrd@pnb.co.in
BHOPAL	BHOPAL	MR. LAKHAN	8085383735	coindhrd@pnb.co.in
INDORE	BHOPAL	RUCHI	8305087810	coindhrd@pnb.co.in
GWALIOR	BHOPAL	Nagendra Singh	9685435649	ogwlhrd@pnb.co.in
JABALPUR	BHOPAL	AMIT VISHWAKARMA	9075004057	cojbphrd@pnb.co.in
UJJAIN	BHOPAL	TANVI UPADHYAY	9644411227	coujjainhrd@pnb.co.in
BALESWAR	BHUBANESWAR	TAPAS MOHANTY	7735099967	COBLSHRD@PNB.CO.IN
BHUBANESWAR	BHUBANESWAR	S K NANDA	8763928175	COBBSRHRD@PNB.CO.IN
CUTTACK	BHUBANESWAR	SANTANU BEHURA	6371293928	COCTCHRD@PNB.CO.IN
BERHAMPUR (GANJAM)	BHUBANESWAR	KUMUD CHANDRA PANDA	9439279757	COBHMHRD@PNB.CO.IN
SAMBALPUR	BHUBANESWAR	AMIT SETHY	8280344893	COSBPHRD@PNB.CO.IN
CHANDIGARH	CHANDIGARH	MR. AJAY KANT	8360351617	cochdahrd@pnb.co.in
HISAR	CHANDIGARH	MR. VIKASH	9309040001	cohshrhd@pnb.co.in
JIND	CHANDIGARH	MS. JYOTSANA	9034595498	cojindhrd@pnb.co.in
KARNAL	CHANDIGARH	MS. SWATI	8285709772	coknlhrd@pnb.co.in
KURUKSHETRA	CHANDIGARH	MR. SHIVDEEP BHARDWAJ	7529007444	cokkrhrd@pnb.co.in
PANIPAT	CHANDIGARH	MR. MAHAVIR GARG	8222891419	copnphrd@pnb.co.in
REWARI	CHANDIGARH	MR. MANISH MEENA	9799923900	corewarihrd@pnb.co.in
ROHTAK	CHANDIGARH	MR. SACHIN	9034929069	Cortkhrd@pnb.co.in
SIRSA	CHANDIGARH	MR. AJAY SAINI	9416646663	cosirsahrd@pnb.co.in
CHENNAI	CHENNAI	Jijeja	9444945642	cochnhrd@pnb.co.in
ERNAKULAM	CHENNAI	Mrs. Prathiba	8921081177	coekmhrd@pnb.co.in
KOZHICODE	CHENNAI	Mrs. Ashwathy	9747552045	cokozhrd@pnb.co.in
THIRUVANTAPURAM	CHENNAI	ANU THAKUR	9988557985	cotvmhrd@pnb.co.in
COIMBATORE	CHENNAI	Mr. Praveen	7708255111	cocoimhrd@pnb.co.in
TRICHY	CHENNAI	M.AKILANDESWARI	9698838283	cotryhrd@pnb.co.in
DEHRADUN	DEHRADUN	MS. RUPEKA	9897622355	co.ddn@pnb.co.in
HALDWANI	DEHRADUN	MR. JITENDER	8171294105	cokashrd@pnb.co.in
HARIDWAR	DEHRADUN	MR. GAUTAM NEGI	8077662080	cohrrdhrd@pnb.co.in
TEHRI	DEHRADUN	MR. DESRAJ RANA	7060701688	cotehrihrd@pnb.co.in
EAST DELHI	DELHI	MS. SEFALI	8054962305	cowdelhrd@pnb.co.in
GHAZIABAD	DELHI	MS. BHAWANA	8171571999	cogzbhrd@pnb.co.in
GURUGRAM	DELHI	MS. KASHISH	9958359472	coggmhrd@pnb.co.in
NOIDA	DELHI	MR. SUMIT	9990097572	conoidahrd@pnb.co.in
NORTH DELHI	DELHI	MR. SAJAL	9829290531	condelhrd@pnb.co.in
SOUTH DELHI	DELHI	MR. RAJESH	9599149030	cosdelhrd@pnb.co.in
WEST DELHI	DELHI	MS. SEFALI	8054962305	cowdelhrd@pnb.co.in
NADIA	DURGAPUR	PANKAJ KUMAR MOURYA	9929453331	conadiahrdrd@pnb.co.in
MURSHIDABAD	DURGAPUR	KOYEL PAUL	8017405462	comurshidhrd@pnb.co.in
PURULIA	DURGAPUR	SANGEETA SURIN	6299211030	copuruliahrd@pnb.co.in

MALDA	DURGAPUR	SUBHRAJYOTI CHOUDHURY	9733206430	comaldahrd@pnb.co.in
NEW JALPAIGURI (SILIGURI)	DURGAPUR	RAJESH SHARMA	7202917724	conjp@pnb.co.in
DURGAPUR	DURGAPUR	JULI KUMARI	9861820777	codgphrd@pnb.co.in
BURDWAN	DURGAPUR	SUBHOJIT BHATTACHARJEE	9614348368	coburhrd@pnb.co.in
AGARTALA	GUWAHATI	AJOY BISWAS	9436521844	coagarhrd@pnb.co.in
IMPHAL	GUWAHATI	TOMYO	8473894545	coimphalhrd@pnb.co.in
GUWAHATI	GUWAHATI	SHANTANU MALAKAR	7002604806	coguwhrd@pnb.co.in
NAGAON	GUWAHATI	Himangshu Deka	9706279096	conagaonhrd@pnb.co.in
SILCHAR	GUWAHATI	Kollol Das	9706483756	cosilcharhrd@pnb.co.in
DIBRUGARH	GUWAHATI	NIRMAL SARKAR	9903480288	codibruhrd@pnb.co.in
JORHAT	GUWAHATI	Mantujit Mudoi	7977756171	cojorhathrd@pnb.co.in
BANGALORE	HYDERABAD	Shri K S Rajendra Prasad	9941982399	cobangaloreeast@pnb.co.in
HUBLI	HYDERABAD	Mrs. Tejashwini	9440979522	cohublihrd@pnb.co.in
HYDERABAD	HYDERABAD	Smt. Garima Bhargav	8197775152	cohydhr@pnb.co.in
SECUNDERABAD	HYDERABAD	Mr.Sh. Sai Ram	7702012300	cosechr@pnb.co.in
VIJAYWADA	HYDERABAD	Mr. Sudhakar Babu	9581106677	coandhrahrd@pnb.co.in
VIZAG	HYDERABAD	E.Kodanda Ravi	7900633330	covizaghr@pnb.co.in
ALWAR	JAIPUR	MR. NITESH	9694003630	coalwhrd@pnb.co.in
BHARATPUR	JAIPUR	MEGHA JAIN	7016606395	cobprhrd@pnb.co.in
BIKANER	JAIPUR	MR. RAMESH KHATRI	9414009289	cobknhrd@pnb.co.in
HANUMANGARH	JAIPUR	MR. KULVINDER SINGH	8740011107	cohamhrd@pnb.co.in
JAIPUR - AJMER	JAIPUR	APORAVA SRIVASTAVA	9352896400	coajmhrd@pnb.co.in
JAIPUR - SIKAR	JAIPUR	DIVYA	7014525186	cosikarhrd@pnb.co.in
JODHPUR	JAIPUR	MR. DINESH JOSHI	9414779440	cojdhrd@pnb.co.in
KOTA	JAIPUR	MR. YOGESH MEENA	8290006611	cokotahrd@pnb.co.in
SRIGANGANAGAR	JAIPUR	MR. GORAV	9414502635	cosgnhrd@pnb.co.in
UDAIPUR	JAIPUR	MR. KISHAN	7023333637	coudaipurhrd@pnb.co.in
HOOGHLY	KOLKATA	Subrata Saha	9836113462	cohooghlyhrd@pnb.co.in
KOLKATA - NORTH	KOLKATA	Subhasis Biswas	9875371799	cokolnorthhrd@pnb.co.in
KOLKATA - WEST	KOLKATA	Shekhar Saraf	9560405119	cokolwesthrd@pnb.co.in
NORTH 24 PARGANAS	KOLKATA	Sumit Dey	9867474320	con24pnhrd@pnb.co.in
SOUTH 24 PARGANAS	KOLKATA	Tashi Doma Lama	9870584099	cokolsouthhrd@pnb.co.in
KOLKATA ZO	KOLKATA	AMIT KUMAR DAS	7228872227	zokolhrd@pnb.co.in
SOUTH 24 PARGANAS	KOLKATA	LIPIKA DAS	9748633473	cosouthparghrd@pnb.co.in
PASCHIM MEDINIPUR	KOLKATA	Subha Ganguly	8945912058	copaschmhrd@pnb.co.in
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