As an American Express Corporate Card member you are automatically entitled (unless specifically excluded) to Complimentary Business Travel Insurance when you charge scheduled common carrier travel tickets to the Corporate Card. The Insurance cover is provided and underwritten by Bharti AXA General Insurance Company Limited and is subject to the Terms & Conditions mentioned there in.

Master Policy Validity: 1st May’2019 to 29th April 2020
Master Policy No: I3800242, I3797333

Policy Wordings
Bharti AXA Travel Assure -Group Overseas Travel Insurance

Preamble & Operative Clause

This Policy is a contract of insurance between the Policyholder and the Company which is subject to (a) the terms, conditions and exclusions of this Policy and (b) the receipt of premium against each Benefit of the applicable in full and (c) the Schedule of Benefits and (d) Disclosure to Information Norm.

Definitions

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule/ Certificate shall bear the same meaning wherever it appears in the Policy, including any subsequent endorsements to this Policy and the Policy Schedule/ Policy Certificate. Where the context permits, references to the singular shall also include references to the plural, similarly references to the male gender shall also include references to the female gender, and vice versa in both cases.

For purposes of this Policy, the terms specified below shall have the meaning set forth:

1. “Accident” means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. “Air Travel” means travel by an airline/aircraft for the purpose of flying therein as a Fare paying passenger.
3. “Any one Illness” means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
4. “Adventure Sports” means and includes skydiving / parachuting, parasailing, hang gliding, paragliding, ballooning, bungee jumping, scuba diving, mountain or rock climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, polo, snow and ice sports, rafting or canoeing involving white water rapids, yachting or boating, Base jumping, Ski jumping, Trekking, Adventure racing on land and water, Snorkeling, Kayaking, and any sporting activity based on bodily contact or which is hazardous or potentially dangerous.
5. “Aggregate Limit” means the Company’s maximum, total and cumulative liability under the Benefit or the set of Benefits as specified in the Policy Schedule or Policy Certificate in respect of all claims by or on behalf of all Insured Persons under the Policy Certificate. If at any time the total value of unpaid claims, if paid, would result in this Aggregate Limit being exceeded, the pays outs under the individual Benefits attributable to those outstanding claims shall be reduced pro rata as necessary to ensure that this Aggregate Limit is not exceeded.
6. “Ambulance” means a vehicle equipped for paramedical treatment and emergency air or surface transportation of a person requiring medical attention, provided by licensed/authorized medical service providers.
7. “Appliances” shall mean and include electrical, mechanical and electronic appliances such as refrigerator, television, DVD player, videocassette recorder/player, washing machine, microwave oven, music system, personal computer, laptops and air-conditioner contained or fixed in the Insured Person’s home for domestic use.
8. “Burglary” means theft involving entry into or exit from the Insured Person’s usual place of residence by forcible and violent means or following assault or violence or threat thereof, to the Insured Person or to any Immediate Family Member or any person residing lawfully in the Insured Person’s residence, with intent to commit a felony therein and includes housebreaking.
9. “Cashless facility” means a facility extended by the insurer to the insured where the payments, 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 is approved.
10. “Catastrophe” means an unexpected natural or man-made event, such as an earthquake, tsunami, flood, civil unrest, mass bandh or riot which causes widespread loss, damage, or disruption in travel schedules.
11. “Checked-in Baggage” means each suitcase or baggage transported under any contract of affreightment.
13. “Common Carrier” means any commercial public airline, railway, motor transport, or water borne vessel (including ocean going and/or coastal vessels and/or vessels engaged for official or personal purposes), operating under license issued by the appropriate authority for transportation of passengers and/or cargo.
14. “City of Origin” means any city in India/ Country of Origin from which the Trip commences, and which is specified in the Policy Certificate.

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BUSINESS TRAVEL INSURANCE CERTIFICATE
15. "Condition Precedent" means a policy term or condition upon which the insurer’s liability under the policy is conditional upon.

16. "Congenital Anomaly" means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. “Internal Congenital Anomaly” refers to the Congenital anomaly which is not in the visible and accessible parts of the body.
   b. “External Congenital Anomaly” refers to the Congenital anomaly which is in the visible and accessible parts of the body.

17. “Contents” mean and include Appliances, furniture, fixture, fittings, linen, clothing, kitchen items, cutlery/crockery contained in the Insured Person’s home belonging to the Insured Person or to any Immediate Family Members permanently residing with the Insured Person including items for which the Insured Person is responsible, and used for domestic use. However, Contents does not include any deeds, bonds, bills of exchange, promissory notes, cheques, traveller’s cheques, and securities for money; documents of any kind, cash and currency notes.

18. “Contribution” is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

19. "Co-Payment" means a cost sharing requirement that the policy holder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

20. "Corporate" means any organization, firm, society or body corporate on whose name the policy is issued.

21. "Cruise" means a Trip involving a sea voyage of at least 1 hours of total duration, where transportation and accommodation is primarily on an ocean going Common Carrier.

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

23. "Day care treatment” means medical treatment, and/or surgical procedure which is:
   i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required hospitalization of more than 24 hours.
   iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

24. “Deductible” means a cost-sharing requirement under this policy, that provides that the insurer will not be liable for a specified amount or percentage of claim amount and/or number of days and/or number of hours as specified in the policy schedule/certificate of insurance which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured and is applicable per event up to the specified limits mentioned.

25. "Defence Costs" are reasonable costs necessarily incurred in defending the Insured Person against any civil proceeding initiated against him/her, during the Trip Duration.

26. “Dependent Child” means a child of the Insured Person whether natural or legally adopted, who is (i) less than age 30 years as of the commencement of the Trip, and (ii) does not have his/her independent source of income and is financially dependent on the Insured Person.

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

28. “Disease” means an alteration in the state of the body or of some of its organs interrupting or disrupting the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

29. "Emergency Assistance Service Provider" means any organization or institution appointed by the Company, for providing services to the Insured Person for an Insured Event covered.

30. “Emergency Care” means management for an 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.

31. "Emergency Hospitalization" means admission of the Insured Person in a Hospital as an in-patient for a minimum period of 24 consecutive hours for an illness contracted or Injury sustained by an Insured Person in an Accident, which occurs suddenly and unexpectedly, and requires immediate medical care to prevent death or serious long term impairment of the Insured Person’s health, as prescribed by a Medical Practitioner.

32. “Family” means the Insured Person, his/her lawful spouse and maximum of any two (2) dependent children.
### Definitions


**34. “Financial Emergency”** means a situation wherein the Insured Person loses all or a substantial amount of his/her travel funds due to theft, robbery, mugging or dacoity, which has detrimental effects on his/her travel plans.

**35. “Foreign Enemy”** means any group of individuals, entity or country, who intend to cause injury, or commission an act dangerous to human life or property in the location where the Insured Person is travelling to, by the use of hostile force or violence.

**36. “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.

**37. “Hijack”** means any unlawful seizure or exercise of control, by force or violence of threat of force or violence and with wrongful intent, of the Common Carrier in which the Insured Person is travelling.

**38. “Hospital”** means any institution established for the treatment of patients which is under constant medical management, has adequate diagnostic and therapeutic facilities, keeps constant medical records, is recognized as a hospital in the country in which it is situated, and which is appropriately licensed, wherever required to be so, to operate as a hospital in that country.

**39. “Hospitalization”** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for day-care procedures/ treatments.

**40. “Illness”** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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:
  - i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
  - ii. it needs ongoing or long-term control or relief of symptoms
  - iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
  - iv. it continues indefinitely
  - v. it recurs or is likely to recur

**41. “Immediate Family Member”** means any member of the Insured person’s immediate family i.e. the insured person’s spouse, child or parent or sibling.

**42. “Inclement Weather”** means any severe catastrophic weather conditions which delay the scheduled arrival or departure of a Common Carrier but not including normal, seasonal/climatic weather changes.

**43. “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

**44. “Inpatient Treatment”** shall mean any Emergency care treatment rendered to the Insured at a Hospital in connection with any Injury or Illness resulting in Hospitalization.

**45. “Insured Event”** means an event, loss or damage specifically described as covered and for which the Insured Person is entitled to benefit/s under this Policy.

**46. “Insured Person”** means the person named in the Policy Certificate, who is an employee or member of the Policy holder and is covered under this Policy upon appropriate premium being paid to the Company.

**47. “Intended Destination(s)”** means area(s) which appear on the scheduled travel itinerary of the Insured Person for stay during the Trip, is/are specified in his/her main travel booking.

**48. “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 another wards.

**49. “ICU Charges”** ICU (Intensive Care Unit) 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.

**50. “Life Threatening Condition”** means a medical condition suffered by the Insured Person which has the following characteristics:

- i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate),
- ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, Liver, Kidneys and pancreas) including ectopic pregnancy.
- iii. Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology.
41. “Immediate Family Member” means any member of the family of the Insured Person or related to the Insured Person by way of blood, marriage, adoption, employment, or any pre-existing business relationship.

42. “Inclement Weather” means seasonal/climatic weather changes.

43. “Injury” means accidental physical bodily harm excluding harm due to natural or genetic causes, as well as psychological trauma, injury to one’s own body or injury to the body of another person, and includes sickness, disease and all other physical injuries, solely and directly caused by external, violent and visible means, which as a result of such injury, the Insured Person is disabled, is unable to carry on any avocation or profession whatsoever or is rendered unable to earn income, excluding all other natural or genetic causes, as well as psychological trauma.

44. “Insurance” means the premium paid to the Company.

45. “Insured Event” means an event, loss or damage specifically described as covered under this Policy.

46. “Insured Person” means the person named in the Policy to benefit under this Policy.

47. “Intensive Care Unit” means an identified section, ward or area(s) which appear on the reverse of the hospital admission/insurance card and are specifically designated by the hospital as being the wing of a hospital which is under the constant supervision of a Medical Practitioner and is equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support and is covered under this Policy upon appropriate premium.

48. “Critical Care” means area(s) which appear on the reverse of the hospital admission/insurance card and are specifically designated by the hospital as being the wing of a hospital which is under the constant supervision of a Medical Practitioner and is equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support.

49. “ICU Charges” means the amount charged by a hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support and other ancillary expenses that may be incurred for ICU as well as for all other expenses incurred during the period of hospitalization.

50. “Medicare” means a medical condition which requires the individual to be under the continuous care of a Medical Practitioner and which requires the individual to be in the hospital for a period of at least two nights.

51. “Loss” means loss or damage.

52. “Mondays” A Man day is a 24 hours period starting from midnight for an individual whilst travelling abroad.

53. “Maternity Expenses” means
   a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization)
   b. expenses towards lawful medical termination of pregnancy during the policy period.

54. “Medical Advice” means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

55. “Medical Advisor” are Medical Practitioners appointed by “Emergency Assistance Service provider”.

56. “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.

57. “Medical Practitioner” means a person who holds a valid registration from the Medical Council or appropriate authority of the country where Insured Person is availing emergency treatment outside India/ Country of origin and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The term Medical Practitioner includes any qualified physician, specialist, or surgeon, and should not be an Immediate Family Member of the Insured Person or related to the Insured Person by way of blood, marriage, adoption, employment, or any pre-existing business relationship.

58. “Medically Necessary Treatment” means any treatment, tests, medication, stay in Hospital or part of a stay in Hospital in relation to the Insured Person which:
   a. is required for the medical management of the Illness or Injury suffered by the Insured Person;
   b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
   c. must have been prescribed by a Medical Practitioner;
   d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

59. “Money” means cash, bank drafts, current coins, bank and currency notes, treasury notes, cheques, traveller’s cheques, postal orders and current postage stamps not forming part of a collection.

60. “Multi Trip” means two or more Trips to Intended Destinations outside India/ Country of Origin during the Period of Insurance.

61. “Multi Trip Cover” means a cover under which the Insured Person can undertake one or more Trips during the Period of Insurance but not exceeding the maximum number of travel days specified in the Policy Certificate.

62. “Non-Network Provider” means any hospital, day care centre or other provider that is not part of the network.

63. “Notification of Claim” means the process of intimating a claim to the insurer or Emergency Assistance Service Provider through any of the recognized modes of communication.

64. “Outpatient 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.

65. “Period of Insurance” means.
   a. In respect of a Single Trip cover, the Period of Insurance is the period from the Coverage Commencement Date/time period specified in the Policy Certificate, to the coverage expiry date/time period specified in the Policy Certificate or end of the actual Trip Duration, whichever is earlier. A Single Trip cover shall not exceed consecutive days/time specified in policy certificate, including departure from and return to the Insured Person’s place of residence.
   b. In respect of a Single Trip cover where the Policy Certificate is issued prior to the Trip for the purpose of obtaining Visa, the Period of Insurance is the period from the Coverage Commencement Date specified in the Policy Certificate or a later date on which the Insured Person’s Trip actually commences, till the coverage expiry date specified in the Policy Certificate or end of the actual Trip Duration, whichever is earlier, but not exceeding consecutive days, as specified in the Certificate of Insurance, including departure from and return to the Insured Person’s place of residence.
   c. “Period of Insurance” in respect of multi trip policy, this means the period from the commencement of insurance cover to the end of actual trip duration or full utilization of the maximum number of travel days per trip as mentioned in the Policy Schedule/Certificate or expiry of the Policy or cancellation of the insurance, whichever is earlier.

66. “Physician” means a Medical Practitioner legally qualified to practice in medicine or Surgery and duly licensed in his/her respective jurisdiction and is not a member of the insured person’s family.

67. “Permanent Partial Disability” means a bodily injury caused by accidental, external, violent and visible means, which as a direct consequence thereof, disables any part of the limbs or organs of the body of the Insured Person and which falls into one of the categories listed in the Table of Benefits.

68. “Permanent Total Disability” means a bodily injury caused
by accidental, external, violent and visible means, which as a
direct consequence thereof totally disables and prevents the
Insured Person from attending to any business or occupation of
any and every kind or if he/she has no business or occupation,
from attending to his/her usual and normal duties that last for a
continuous period of twelve calendar months from the date of
the accident, with no hopes of improvement at the end of that
period.

69. “Policy” means the Schedule, the Policy documents and any
endorsements attaching to or forming part hereof either on the
commencement date or during the Policy Period.

70. “Policy Certificate” means the certificate issued to the
Insured Person evidencing the Insured Person’s cover under the
Policy.

71. “Policy Period” means the period between the
Commencement Date and the Expiry Date of the Policy as
specified in the Policy Schedule/Policy Certificate.

72. “Policyholder” means and includes an individual,
organization, firm, society or body corporate whose name the
policy is issued.

73. “Port” means a scheduled point of departure or arrival of a
Common Carrier in which an Insured Person is booked to travel.

74. “Pre-existing Condition” means any condition, ailment or
injury or related condition(s) for which the Insured Person had
signs or symptoms, and/or was diagnosed, and/or received
medical advice/treatment within 48 months prior to the
Coverage Commencement Date.

75. “Professional Sportsperson” means those sports persons
who are in to full time sports and maintain their livelihood
through earnings derived from their involvement in sports.

76. “Reasonable Additional Expenses” means any expenses for
meals, temporary accommodation, emergency communication
and purchases of toiletries, medication and clothing necessarily
incurred by the Insured Person and not provided by the
Common Carrier, or any other individual/entity, free of charge.

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

78. “Renewal” means 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 gaining credit for pre-existing diseases, time-bound
exclusions and for all waiting periods.

79. “Room Rent” means the amount charged by a hospital for
the occupancy of a bed on per day (24 HRS) basis and shall
include associated medical expenses.

80. “Schengen Countries” are a group of countries that includes
Austria, Belgium, Czech Republic, Denmark, Estonia, Italy,
Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Norway,
Poland, Portugal, Slovakia, Slovenia, Sweden, Switzerland. The
list of these countries is subject to update from time to time as
and when necessitated by the relevant authorities.

81. “Semi-Professional sportsperson” shall mean those sports
persons who participate in sports and get remuneration for
participating, but whose primary source of income is not from
sports.

82. “Single Trip Cover” means a cover under which the Insured
Person can undertake only one Trip during the Period of
Insurance.

83. “Strike” means stoppage of work announced, organized and
sanctioned by a labour union, inclusive of work slowdowns,
lockouts and sickouts, which interferes with the normal
departure and arrival of a Common Carrier.

84. “Sub-limit” means a cost sharing requirement under a policy
in which an insurer would not be liable to pay any amount in
excess of the pre-defined limit. As specified in the Certificate of
Insurance a sublimit can also be interpreted in time - hours/days

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

86. “Sum Insured” means the amount specified in the Policy
Certificate against a Benefit or set of Benefits, which represents
the Company’s maximum, total and cumulative liability for any
and all claims made in respect of the Insured Person during the
Period of Insurance, under that Benefit/set of Benefits. Sum
Insured can be a lump sum benefit payment upon occurrence of
an insured event or indemnity payment basis expenditure of the
Insured Person for coverage as specified in the Policy Wording
upon occurrence of the insured event.

87. “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 from suffering and prolongation of life,
performed in a hospital or day care centre by a medical
practitioner.

88. “Terrorism/Terrorist Incident” means any actual or
threatened use of force or violence directed at or causing
damage, injury, harm or disruption, or the commission of an act
dangerous to human life or property, against any individual,
property or Government, with the stated or unstated objective of
pursuing economic, ethnic, nationalistic, political, racial or
religious interests, whether such interests are declared or not.
Robberies or other criminal acts, primarily committed for
personal gain and acts arising primarily from prior personal
relationships between perpetrator(s) and victim(s) shall not be
considered terrorist activity. Terrorism shall also include any act,
which is verified or recognized by the relevant Government as an
act of terrorism the insurance Policy or travel arrangements, and
includes all officers, employees and affiliates of the Travel Agent,
tour.
90. "Theft" means an act of illegally, permanently and directly or indirectly depriving the Insured Person of his or her personal belongings or any property by violent or forceful means.

91. "Travelling Companion" means an individual or individuals travelling with the Insured Person, provided that the Insured Person and such individual(s) are travelling to the same Intended Destination and on the same date and such individual(s) is/are also insured with the Company. For the purpose of this definition, any individual(s) forming part of a group travelling on a tour arranged by a travel agent or a tour operator shall not be considered as Travelling Companion, unless the individual(s) is/are Immediate Family Members of the Insured Person.

92. "Trip" means a journey originating from the residence of the Insured Person to out of the Republic of India/Country/City of Origin and back to the Republic of India/Country/City of Origin of the Insured Person, the details of which are specified in the Policy certificate/Schedule.

93. "Unattended" A Vehicle, premises or personal belongings that are unattended if there is no one able to observe or to prevent interference with it.

94. "Unproven/Experimental treatment" means the treatment including drug experimental therapy which is not based on established medical practice in India or in the country where such treatment is undertaken.

95. "Valuables" mean and include photographic, audio, video, computer and any other electronic and electrical equipment, cellular phones, data, business goods, telecommunications and electrical equipment, motor vehicles, documents and any accessories, sculptures, manuscripts, rare books, plan, medals, moulds, designs, telescopes, binoculars, antiques, watches, jewellery, furs and articles made of precious stones and metals.

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<tr>
<th>Benefits</th>
<th>Geographical Scope</th>
<th>Sum Insured</th>
<th>Deductible</th>
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<tr>
<td>Common Carrier</td>
<td>Worldwide</td>
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<tr>
<td>Accidental Death</td>
<td>Worldwide</td>
<td>INR 500000</td>
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<td>Personal Accident-Permanent Total Disability (PTD)</td>
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<td>IN-Hospital Medex (Inpatient)</td>
<td>Limited to Domestic</td>
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<td>Loss of Passport and Documents</td>
<td>Limited to Overseas</td>
<td>USD 150</td>
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<tr>
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<th>Sum Insured</th>
<th>Deductible</th>
</tr>
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<td>USD 150</td>
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</table>
Special Terms & Conditions - Applicable to all categories

- This Travel Insurance policy is only valid for Amex Valid card holders for all INR Corporate card members/Business Travel Accounts wherever they are in the world except sanctioned countries and limited to number of cards applicable to each card category.
- Age limit is up to 65 years only & per trip duration should not exceed 30 days in case of Multi Trip.
- Pre-existing condition(s) are excluded from the policy. This exclusion will apply to the following sections: Emergency Medical Expenses, Extension to Emergency Medical Expenses section, Emergency Medical Evacuation, Repatriation of Mortal Remains Dental Treatment Expenses, Daily Allowance in case of Hospitalization, Compassionate Visit, Study Interruption, Home Country Cover, University Excess Medical Cover, Permanent Total Disability (PTD), Permanent Partial Disability (PPD).
- Pre-existing’s conditions(s) are excluded from the policy including but not limited to unforeseen emergency measures to save the Insured/insured person’s life. This excluding will apply to the following sections: Emergency Medical Expenses, Emergency Medical Evacuation, Dental Treatment Expenses, Daily Allowance in case of Hospitalization, Permanent Total Disability (PTD), and Permanent Partial Disability (PPD).
- SANCTIONS LIMITATION AND EXCLUSION CLAUSE No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment or such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanction, laws or regulations of the European Union, United Kingdom or United States of America. Excluding from/to and/or countries/places prohibited by GOI &also Specifically Excluding Iran / North Korea / Sudan / Syria / Belarus / Cuba / Crimea (including SEVASTOPOL) [i.e. a region and main port city of Ukraine annexed by Russia].
- Subject to the terms, conditions and exclusions of the Bharti AXA Travel Assure -Group Overseas Travel Insurance and Group Personal Accident
- Warranted that the Total loss of checked in baggage, Delay of checked in baggage is covered limited to Air Travel Mode only.
- Policy can be issued to the customers who are travelling only from India as per the trip details mentioned in scheduled tickets.
- In case of death claims, the benefit will be paid to the insured’s nominee(s) and if no person has been nominated, then to the legal heirs of the insured.
- Warranted that the Common Carrier, Accidental Death and Personal Accident - Permanent Total Disability is having a World Wide coverage excluding Sanctioned countries.
- Covered Person” Unless specifically excluded, an individual who has a corporate card billed in Indian Rupees issued by American Express Banking corp. in his or her name. All the benefits mentioned under the policy are payable only if the ticket is purchased on a valid corporate card or travel is booked on the business travel account/central corporate card with a valid spending of at least rupee1 in the previous 12 months from the date of claim. Irrespective of which corporate card is charged for purchasing the ticket. The person would be covered as long as he/she has a valid corporate card issued in his/her name. The cover is available for the entire trip wherein case of a single ticket, the risk starts from the point the insured person leaves the residence /office his scheduled flight and continues during air journey and ends when the insured reaches his/her destined hotel or place of stay at destination. In case of closed loop ticket, the risk starts from the point the insured person leaves his residence for his scheduled flight and continues during the entire journey and ends when the insured person reaches his residence/offices.
2. Benefits under the Policy:

The Policy Certificate will specify Benefits that are in force for the Insured Person during the Period of Insurance. Claims made under any applicable Benefit for the Period of Insurance will be subject to the terms, conditions and exclusions of this Policy wording, the availability of the Sum Insured for that Benefit, any applicable sub-limits and/or Deductibles.

Section : Emergency Medical Expenses

Coverage
The Company shall pay or reimburse to the Insured/Insured Person Emergency Care expenses incurred for availing immediate emergency medical assistance required on account of any disease/illness contracted or injury sustained whilst on a trip up to the limit of Sum Insured or sub-limit specified in the Policy certificate. In the event, the Insured/Insured Person contracts disease/illness or sustains injury during the Policy period; the Company will pay or reimburse to the Insured/Insured Person emergency care expenses subject to the Sum Insured or sublimit for any or all of these benefits as specified in the Policy Certificate. The Insurer’s liability to make payment is only in excess of the Deductible as specified in policy certificate.

1. Out-patient treatment, provided, the same is critical and cannot be deferred till the Insured’s/Insured Person’s return to the Republic of India.
2. In-patient treatment in a local hospital at the place the Insured/Insured Person is staying at the time of occurrence of an insurable event including but not limited to the following:
   a. Room Rent including Boarding lodging
   b. Intensive Care Unit
   c. Surgery
   d. Anesthetist Services
   e. Physician Visit
3. Medical aid prescribed by a Medical Practitioner as necessary part of a treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).
4. Radiotherapy, heat therapy or photo therapy and other such treatment prescribed by a Medical Practitioner.
5. X-ray, diagnostic tests and all reasonable costs towards diagnostic methods and treatment of all disease/illness/injury provided these pertain to the disease/illness/injury due to which hospitalization was deemed necessary.
6. Cost of transportation, including necessary medical care, by recognized medical service providers for medical attention to the nearest hospital or to the nearest Medical Practitioner or to a special clinic if prescribed by a Medical Practitioner.

Special Conditions applicable for Emergency Medical Expenses, Emergency Medical Evacuation & Repatriation of Mortal Remains

1. Sum Insured for Emergency Medical Evacuation & Repatriation of Mortal Remains can be specified separately or as a Sub Limit to the Sum Insured specified in the Emergency Medical Expenses Section as specifically mentioned in the Policy Certificate.
2. If any disease/ illness/ injury during the period abroad necessitate curative treatment beyond duration of this insurance, the Company’s liability to pay benefits within the scope of this Policy shall extend automatically for a further period of 30 days insofar as it can be proved that transportation home is not possible. Emergency Service Assistance Provider must be notified immediately as soon as it is known that Insured/ Insured Person is unfit to return to India. If any new disease/illness/ injury are contracted beyond duration of this Policy, treatment for the same will not be covered. Company’s liability does not exceed the Sum Insured or sub limit specified in the policy certificate.
3. Further, in case of transportation home on the advice of Emergency Assistance Service Provider, appropriate continued treatment in India for the same disease/ illness/ injury will be covered for a maximum of 30 days beyond this Policy period automatically, provided the disease/ illness/ injury is contracted abroad within this Policy period. The transportation of the Insured/Insured person back to India shall be done only on agreement and confirmation from the attending medical practitioner that the Insured/ Insured Person is capable of being transported to India. Company’s liability does not exceed the Sum Insured or sub limit specified in the policy certificate.
4. If Emergency Assistance Service Provider recommends that continued treatment in an Indian hospital is appropriate, this Policy shall be extended automatically to cover medical expenses incurred in India as specified in the Medical Expenses Cover in this Policy provided that such expenses will only be paid at the usual and customary level for such services, and further provided that expenses will only be paid for treatment incurred within the 30 days period immediately following the first manifestation of the disease/ illness/ injury during the trip. Company’s liability does not exceed the Sum Insured or sub limit specified in the policy certificate.

a. Special Sublimit: Special Sub Limit to the Sum insured specified in the Emergency Medical Expenses Section as specifically mentioned in the Policy Certificate table.

Definition limited to Special Sublimit
a. “Room Rent including Boarding lodging” means the amount charged by a hospital for the occupancy of a bed on per day (24 HRS) basis and shall include associated medical expenses.
b. “Intensive Care unit” means visit to emergency department or ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s) and equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities where the level of care and supervision is more intensive than in the ordinary and other wards.
c. “Operation Theatre charges (Inclusive surgeon charges)” means operation theatre charges, surgeon fees(inpatient / outpatient / day care procedure), implant charges and all other associated charges which is payable as per policy conditions.
d. “Ambulance Services” means include cost of transportation of the insured person to the nearest hospital and paramedic services.
e. “Anesthetist services” means connection with inpatient surgery or outpatient procedures or day care procedures/ surgery.
f. “Physician Visit” means one physician visit per day but not applicable in case of surgery.
g. “Diagnostic and Radiology services” means test prescribed by Medical practitioner

h. “Hospital Miscellaneous Expenses” while hospital confined; benefits will be cover for services and supplies such as the cost of operating room; laboratory tests; x-ray examination; drugs (excluding take home drugs) or medicines and supplies.

Specific Exclusions Applicable to Emergency Medical Expenses, Emergency Medical Evacuation and Repatriation of Mortal Remains

The Company shall not be liable to make any payment under this benefit in connection with or in respect of any expenses whatsoever incurred by the Insured/ Insured Person for:

1. Where the insured person is travelling against the advice of a physician or receiving or on a waiting list for specified medical treatment; or is travelling for the purpose of obtaining treatment or has received a terminal prognosis for a medical condition
2. Treatment of orthopedic, degenerative, oncological diseases, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured/ Insured person’s life or amount specified in Policy Certificate.
3. Treatment which could be reasonably delayed until Insured/Insured Person’s return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner and the Company and shall be in accordance with accepted standards of medical care.
4. Charges in excess of reasonable and customary charges incurred for emergency treatment on account of an insured event.
5. Treatment relating to the removal of physical flaws or anomalies (cosmetic treatment or plastic surgery in any form or manner unless medically required as part of treatment for cancer, accidents and burns).
6. Expenses incurred in connection with rest or recuperation at a spa or health resort, sanatorium, convalescence home or similar institution or related to treatment of alcoholism or drug dependency.
7. Maternity, child birth and any consequences, including changes in other chronic conditions as a result of pregnancy. However, this exclusion will not apply in following cases:
   a) Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
   b) If the medical assistance provided abroad involves unforeseen emergency measures to save the Insured’s/ Insured Person’s or the child’s life in the event of acute complications, provided that the Insured/ Insured Person has not completed the age of 38 years and the 30th week of the pregnancy is not yet completed.
8. Rehabilitation and/or physiotherapy or the costs of prostheses/ prosthetics (artificial limbs) etc. However, expenses towards physiotherapy related to disease/ illness/ injury requiring outpatient/ inpatient care, subject to the specified limits and conditions, will be covered if specifically agreed for and specified in the Policy certificate.
9. Any exclusion mentioned in the ‘General Exclusions’ section of this Policy.

All Specific exclusions and special conditions applicable to Emergency Medical Expenses, Emergency Medical Evacuation, Repatriation of Mortal Remains shall be applicable to this section also.

Section :Loss of Passport and documents Coverage

If the Insured Person’s passport is lost or stolen during a trip abroad, the Company shall reimburse the actual expenses necessarily and reasonably incurred in connection with obtaining a duplicate or fresh passport or issuance of an Emergency Certificate from the concerned consulate, up to the limit of Sum Insured or limits specified against this Benefit in the Policy Certificate.

This Section also provides for reimbursement of actual expenses necessarily and reasonably incurred in connection with obtaining/ replacing the stolen travel documents/tickets and travelers cheques up to the limit of Sum insured for this benefit, if such documents/tickets/ travelers cheques belonging to the Insured/ Insured Person be lost whilst on a trip. The Insurer’s liability to make payment is only in excess of the Deductible as specified in policy certificate.

This Benefit is payable subject to the following:
1. The incident is to be reported to the police within 24 hours of the Insured Person becoming aware of the theft, and a written police report is to be furnished to the Company.
2. A Deductible of an amount specified in the Policy Certificate shall be separately applicable for each and every claim made under this Benefit.

Specific Exclusion:

The Company shall not be liable to make any payment for any claim for loss or theft in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:
1. Any delay or confiscation or detention by the customs, police or public authorities.
2. Any loss of the passport in a public place or in a public transport, due to the Insured Person’s failure to take reasonable precautions to avoid such loss.
3. Loss or theft of the passport from an unlocked private hotel room/apartment/vehicle, unless forcible and violent entry was used to gain access to it.
4. Any exclusion mentioned in the “General Exclusions” Section of this Policy.

This cover is also available as a fixed benefit option upto the sum insured clearly specified in the policy certificate or under the special conditions of the policy certificate, subject to admissible claim as per the policy conditions applicable to this section including specific exclusion and to any other condition applicable to this policy. In respect to process claims documents specified under Documentation section is necessary to evaluate the claim. All terms & conditions applicable to this cover remains same as mentioned in coverage, specific exclusion, General exclusion applicable to this section.
Section : Total Loss of Checked-in Baggage Coverage
In the event of total and complete loss of Checked-in Baggage whilst on a Trip and whilst it is in the custody of the Common Carrier, the Company shall reimburse the Insured Person for the Market Value of such Checked-in Baggage up to the limit of Sum Insured or sub limit specified against this Benefit in the Policy Certificate.

For the purpose of this Benefit, “Market Value” refers to the amount required to purchase new items of the same kind and quality as those contained in the Checked-in Baggage, in relation to which a claim is under this benefit, less applicable depreciation @25% per annum from the date of purchase, calculated as at the time of loss. Maximum depreciation applicable under this benefit shall not exceed 60% in any event.

The cover is applicable only at the Intended Destinations, and is limited to the period commencing from the time the Checked-in Baggage is entrusted to the Common Carrier and return of the Insured Person back to the City of Origin, or any other Port in India/ Country of Origin along with all halts and via destinations included in the travel booking.

This Benefit shall be payable subject to the following:
1. In the event of such a total and complete loss of Checked-in Baggage whilst in the custody of the Common Carrier, a Property Irregularity Report (PIR) must be obtained from the Common Carrier immediately upon discovery of the loss which must be submitted along with the claim.
2. A Deductible of an amount specified in the Policy Certificate shall be separately applicable for each and every claim made under this Benefit.
3. Our maximum liability under this Benefit in respect of any one Checked-in Baggage, in case more than one bag has been checked-in, is 50% of the applicable Sum Insured. In case of only one bag being checked-in, the maximum liability is up to 100% of the applicable Sum Insured.
4. The Company has been provided with all the documents, reports and other details from the Common Carrier confirming the loss of Checked-in Baggage in its custody.
5. If the Company makes any payment under this benefit, it is agreed that any recovery from any Common Carrier by the Insured Person, under the terms of the Convention for the Unification of Certain Rules Relating to International Carriage by Air, 1929 (“Warsaw Convention”) shall become the property of the Company.
6. Any partial loss of the items contained within the Checked-in Baggage, not amounting to a total and complete loss of such Checked-in Baggage, shall not be payable.
7. In the event of simultaneous claims under this Benefit as well as under Delay of Checked-in Baggage, the higher of the claims shall be payable by the Company in respect of the same item(s) of Checked-in Baggage during any one Period Of Insurance.

Specific Exclusions:
The Company shall not be liable to make any payment for any claim under this Benefit of the Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:
1. Valuables, Money, any kind of securities and tickets/passes or any other item not declared and/or agreed by the Company.
2. Loss of any Checked-in Baggage unless a Property Irregularity Report or other report usually issued by the Common Carrier in the event of loss of Checked-in Baggage has been procured and submitted to the Company.
3. Any partial loss of the items contained within the Checked-in Baggage.
4. Losses arising from any delay, detention, confiscation by the customs officials or other public authorities.
5. Any Checked-in Baggage loss while the Insured Person is in India/ Country of Origin.
6. Any exclusion mentioned in the “General Exclusions” Section of this Policy

This cover is also available as a fixed benefit option up to the sum insured clearly specified in the policy certificate & under the special conditions of the policy certificate & subject to admissible claim as per the policy conditions applicable to this section including specific exclusion and to any other condition applicable to this policy. In respect to process claims documents specified under Documentation section is necessary to evaluate the claim. All terms & conditions applicable to this cover remains same as mentioned in coverage, specific exclusion, General exclusion applicable to this section.

Section : Delay of Checked-in Baggage Coverage
The Company shall pay or reimburse to the Insured/ Insured Person for costs of necessary emergency purchases of toiletries, medication and clothing in the event of the Insured/Insured Person for the delay in scheduled arrival of the checked-in baggage caused by a Common Carrier, on a trip up to the Sum Insured or limits specified in the Policy certificate or the expenses incurred by the Insured person towards transportation for recovering the checked-in baggage from the common carrier. The cover is limited to the travel destinations specified in the main travel ticket from the Republic of India with all halts and via destinations included in the main travel ticket and declared at the time of purchase of this Policy. The Insurer’s liability to make payment is only in excess of the Deductible as specified in policy certificate.

This Benefit shall be payable subject to the following:
1. For each and every claim made under this Benefit, a Deductible of number of hours specified in the Policy Certificate shall be separately applicable in terms of delay in arrival of the Checked-in Baggage from the actual arrival time of the Common Carrier at the Insured Person’s Intended Destination.
2. The Company is provided with a proof of such delay in writing from the Common Carrier.
3. The Company is provided with the receipts of the purchase of toiletries, medication and clothing that the Insured Person needed to buy in the duration of such delay.
4. If the Company makes any payment under this benefit, it is agreed that any recovery from any Common Carrier by the Insured Person, under the terms of the Convention for the Unification of Certain Rules Relating to International Carriage by Air, 1929 (“Warsaw Convention”) shall become the property of the Company.
5. In the event of simultaneous claims under this Benefit as well as under Total Loss of Checked-in Baggage, the higher of the claims shall be payable by the Company in respect of the same...
Item(s) of Checked-in Baggage during any one Period Of Insurance.

This cover is also available as a fixed benefit option up to the sum insured clearly specified in the policy certificate or under the special conditions of the policy certificate & subject to admissible claim as per the policy conditions applicable to this section including specific exclusion and to any other condition applicable to this policy. In respect to process claims documents specified under Documentation section is necessary to evaluate the claim. All terms & conditions applicable to this cover remains same as mentioned in coverage, specific exclusion, General exclusion applicable to this section.

Specific Exclusions:

The Company shall not be liable to make any payment for any claim under this Benefit of the Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:
1. Valuables, Money, any kind of securities and tickets/passes or any other item not declared and/or agreed by the Company.
2. Loss of any Checked-in Baggage unless a Property Irregularity Report or other report usually issued by the Common Carrier in the event of loss of Checked-in Baggage has been procured and submitted to the Company.
3. Any partial loss of the items contained within the Checked-in Baggage.
4. Losses arising from any delay, detention, confiscation by the customs officials or other public authorities.
5. Any delay while the Insured Person is in India/ Country of Origin.

Section: Missed Connection:

Coverage

In the event of an insured person failing to board any common carrier onwards to an intended destination due to a delay or cancellation of a prior connecting common carrier, including any change of route, non-landing/docking or offloading of passenger due to overbooking, and provided that any such delay or cancellation is not caused due to, arising out of or in consequence of any acts omissions of the insured person, the company shall reimburse up to the limit of following expenses (post deduction of compensation offered by service provider/common carrier or any other source) and subject to the limit of sum insured specified against this benefit in the policy certificate. The Insurer’s liability to make payment is only in excess of the Deductible as specified in policy certificate.

1. Non-refundable, unused portion of the pre-paid expenses but limited to lodging cost and/or the ticket cancellation charges, as long as these expenses are supported by a proof of purchase and is not reimbursable by another source.
2. Such delay must be authenticated by the common carrier in writing.
3. Reasonable expenses towards alternative travel bookings made up to such intended destination as may be absolutely necessary by any other common carrier.

4. Reasonable and necessary costs of upgradation of travel booking to a superior class in the same form of Common Carrier subject to same category of travel booking is not available & same has been confirmed by travel provider.
5. Necessary expenses incurred towards Reasonable Additional Expenses, if not provided by the common carrier or other third party, subject to production of bill/receipts if this cover has been offered on indemnity basis.
6. Reasonable and necessary costs of upgradation of accommodation arrangements provided in cases where only partial services are provided by the concerned travel provider subject to same category of travel booking is not available & same has been confirmed by travel provider.

This cover is also available as a fixed benefit option up to the sum insured clearly specified in the policy certificate or under the special conditions of the policy certificate & subject to admissible claim as per the policy conditions applicable to this section including specific exclusion and to any other condition applicable to this policy. In respect to process claims documents specified under Documentation section is necessary to evaluate the claim. All terms & conditions applicable to this cover remains same as mentioned in coverage, specific exclusion, General exclusion applicable to this section.

Specific Exclusions

This benefit does not cover any other loss other than those mentioned above under the head “coverage”, directly or indirectly, in whole or in part, including loss caused by or resulting from any exclusion mentioned in the ‘General Exclusions’ section of this Policy.

GENERAL EXCLUSIONS (APPLICABLE TO ALL BENEFITS UNDER THE POLICY):

In addition to the exclusions that are applicable for the specific sections of the Policy as mentioned above in this Policy, the following exclusions apply to benefits under all Sections of the Policy.

Without prejudice to anything contained in this Policy, the Company shall not be liable to make any payment in respect of, unless specifically stated otherwise in the Schedule or certificate to the Policy:

1. Any claim relating to events occurring before the commencement of the cover or otherwise outside of the period of insurance.
2. Pre-existing condition(s) are excluded from the policy including but not limited to unforeseen emergency measures to save the insured/insured person’s life. This exclusion will apply to the following sections: Emergency Medical Expenses, Extension to Emergency Medical Expenses section, Emergency Medical Evacuation, Repatriation of Mortal Remains Dental Treatment Expenses, Daily Allowance in case of Hospitalization, Compassionate Visit, Study Interruption, Home Country Cover, University Excess Medical Cover, Permanent Total Disability (PTD), Permanent Partial Disability (PPD), however, this exclusion can be waived Upon realization of additional premium and will be indicated in the Policy Certificate along with the corresponding sub-limit.
3. Pre-existing condition(s) are excluded from the policy. This exclusion will apply to the following sections: Emergency
Medical Expenses, Extension to Emergency Medical Expenses section, Emergency Medical Evacuation, Repatriation of Mortal Remains Dental Treatment Expenses, Daily Allowance in case of Hospitalization, Compassionate Visit, Study Interruption, Home Country Cover, University Excess Medical Cover, Permanent Total Disability (PTD), Permanent Partial Disability (PPD), however, this exclusion can be waived upon realization of additional premium and will be indicated in the Policy Certificate along with the corresponding sub-limit.

4. Treatment abroad if that is the sole reason or one of the reasons for the Insured/Insured Person’s temporary stay abroad.

5. Any claim if the Insured Person -
   a. Is travelling against the advice of a Physician;
   b. Is receiving, or is on a waiting list to receive, specified medical treatment declared in the Physician’s report or certificate;
   c. Has received terminal prognosis for a medical condition;
   d. Is taking part in a naval, military or air force operation.

5. Deductibles as specified in the Policy Schedule/Policy Certificate.

6. No claim will be paid arising from suicide, attempted suicide or willfully self-inflicted injury or illness, mental disorder, anxiety, depression, venereal disease, alcoholism, drunkenness or the abuse of the drugs, or any loss arising directly or indirectly from any injury, illness, death, loss, expenses, or other liability attributable to HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or any mutant derivative or variation thereof however caused.

7. Congenital external diseases, defects or anomalies -

8. Diseases, illness and accidents that are results of war and warlike occurrence or invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, active participation in riots, confiscation or nationalisation or requisition of or destruction of or damage to property by or under the order of any government or local authority.

9. Any claim resulting or arising from or any consequential loss, directly or indirectly, caused by or contributed to or arising from:
   a. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or
   b. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

10. Any claim arising out of sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons, Adventure Sports unless declared beforehand and necessary additional premium paid.

11. No claim will be paid which arises from the insured Person engaging in Air Travel unless he or she flies as a passenger on an aircraft properly licensed to carry passengers. For the purpose of this exclusion, Air Travel means being in or on, or boarding an aircraft for the purpose of flying therein or alighting therefrom following a flight.

12. Medical Expenses in respect of Experimental, investigational or unproven treatments or treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.

13. Any claim arising out of diseases, illnesses or accidents that the Insured/Insured Person has caused intentionally or by committing a crime or as a result of drunkenness or addiction (drugs, alcohol). However, treatment of mental and nervous disorders, including alcohol and drug dependency, will be covered subject to the limits specified in the Policy Schedule/Policy Certificate, if specifically agreed for and mentioned in the Policy Schedule/Policy Certificate. The payment for such medical expenses shall be limited to inpatient hospitalization in a Hospital/Nursing Home for a period more than 24 hours.

14. Any claim arising out of any act of terrorism which means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological, or ethnic purposes or reasons including the intention to influence any government and/or to put the public or any section of the public, in fear. This shall not apply in respect of Section - Hijack Distress Allowance.

15. Naturopathy treatment

16. No claim will be paid for losses arising from accidents on two wheeled motorized vehicles unless at the time of the accident the driver is duly qualified, is in possession of a current full international Driving License and the Insured Person is wearing a safety crash helmet, or losses arising from accidents on two wheeled motorized vehicles over 50 cc.

17. No claims will be paid for losses arising directly or indirectly from hazardous occupation or if engaging in any criminal or illegal act.

GENERAL CONDITIONS OR PROVISIONS UNDER THE POLICY (APPLICABLE TO ALL BENEFITS UNDER THIS POLICY)

1. The deductible in respect of this benefit will be applicable for each and every claim separately and shall be of an amount as specified in the Policy Schedule/Policy Certificate.

2. Policies covering single trips can be issued upto single trip not exceeding 365 days.

3. Of the covers indicated in this policy wording coverage available to the insured will be indicated in the Certificate of Insurance along with Sum Insured and Deductibles.

4. Policies covering annual multi trips can be issued for annual period of one year covering multiple single trips within the annual period of insurance with each and every single trip not exceeding a specified number of days as mentioned in the Policy Schedule/Policy Certificate.

5. The Policy start date shall be on or before the trip start date.

6. Extension of the Period of Insurance of the Policy during the duration of the trip can be done only at the sole discretion of the Company depending upon the risk factors.

7. If the Insured/Insured Person does not declare the full current facts or declare wrong facts while requesting for extension of the Policy, any extension of such a Policy if granted shall be deemed to be invalid. No refund of premium will be given in case of extensions so invalidated. The Company will also not be liable to pay any claim filed under the extended Policy.

8. Termination of the Policy at a date earlier than the end date can be done only if the Insured Person returns back to the...
Republic of India earlier than the end date of the Period of Insurance of the Policy. Refund of premium for the days between the return date to the Republic of India and the end date of the Period of Insurance as mentioned in the Policy Schedule/Policy Certificate will only be given if the same are a minimum of 10 days. A cancellation charge will be deducted from the refund premium. Premium refunded will be equal to the amount of premium to be paid for the original Policy duration minus the premium to be paid by taking the return date as the new end date of Period of Insurance. No refunds will be given on policies with claims.

9. The premium payable for the extension of the Policy during the trip duration shall be the premium payable for the overall trip duration (including the extension) less the initial premium already paid.

10. Policy is applicable for one-way travel also, including immigration travel with a condition for maximum duration of coverage limited to specified number of days as mentioned in the Policy Schedule/Policy Certificate.

11. The Insured Person shall take all reasonable precautions in the normal course, to stay healthy and prevent disease, illness and injury. Failure to do so will prejudice the Insured/Insured Person's claim under this Policy.

12. The Insured / Insured Person shall provide the Company with the details of the trip and other information as may be required by the Company from time to time.

13. Deductible will be charged for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once.

14. Claim Procedure - The procedure to be followed by the Insured / Insured person in case of any event that may give rise to a claim under this Policy, the claim documentation required to be submitted by the Insured / Insured Person at the time lodging claims as well as the claim settlement process are enumerated in the enclosed Claim Procedure attached to this Policy. Any failure on the part of the Insured / Insured Person in complying with the procedure or submission of required documents in support of his/her claim may prejudice the claim of the Insured/Insured Person.

15. Obligations of the Insured /Insured Person:
   a. Insured / Insured Person shall provide to the Company or the Emergency Service Provider appointed by the Company, on demand any information that is required to determine the occurrence of the insurable event or the Company's liability to pay the benefits.
   b. If requested to do so by the Company or the Emergency Service Provider appointed by the Company, the Insured / Insured Person is obliged to undergo a medical examination by a Medical Practitioner designated by the Emergency Service Provider for the purpose of settlement of claims only. The cost towards the medical examination shall be borne by the Company.
   c. The Company or the Emergency Service Provider appointed by the Company is authorized to take all measures that are suitable for loss prevention and claim minimization which includes the Insured / Insured Person’s transportation back to the Republic of India. The transportation of the Insured / Insured person back to India shall be done only on agreement and confirmation from the attending medical practitioner/ panel doctor that the Insured/Insured Person is capable of being transported to India.
   d. The Company shall be released from any obligation to pay benefits under this Policy, if any, of the aforementioned obligations are breached by the Insured/ Insured Person.

16. Transfer and Set-off of Claims:
   a. If the Insured / Insured Person have any outstanding claims against third parties, such claims shall be transferred in writing to the Company up to the amount for which the reimbursement of costs is made by the Company in accordance with the terms hereunder.
   b. In so far as an Insured / Insured Person receives compensation for costs he/she has incurred either from third parties liable for damages or as a result of other legal circumstances, the Company shall be entitled to set off this compensation against the insurance benefits payable.
   c. Claims to the insurance benefits may be neither pledged nor transferred by the Insured/Insured Person. Transfer and Set-Off of Claims shall not be applicable to any Medical Sections under the Policy namely Emergency Medical Expenses, Emergency Medical Evacuation, Repatriation of Mortal Remains, Dental Treatment Expenses, Personal Accident, Accidental Death and Permanent Total Disablement – Common carrier Coverage, Daily allowances in case of Hospitalization.

17. The premium charged shall be based on the number of man days insured in each category at the commencement of the Policy Period, as declared by the Insured Person. Depending on the actual number of man days covered in the Policy Period in each category as at the last day of such Policy period, if the premium calculated on the actual number of man days shall differ from the premium charged at the commencement of the Policy, then such difference shall be paid to the Company or refunded by the Company as the case may be.

18. Multiple Claims: In the event a claim is payable in multiple sections under this policy the Company’s liability will be restricted to the highest amount payable per section.

19. In case a covered insured event, as described in the Benefit Section, occurs before date of purchase of this policy or advance warning is issued by the relevant authorities of the likelihood of such an event happening before date of purchase of this policy the Company shall not be liable to pay a claim.

GENERAL TERMS AND CONDITIONS (APPLICABLE TO ALL SECTIONS OF THIS POLICY)

1. Duty of Disclosure or Disclosure to information norm
   The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent “means or device being used by the Insured/Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

2. Observance of terms and conditions
   The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured / Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

3. Geography
   The geographical scope of this policy applies to events limited to the Geographical Area of Cover opted and which are specified in the Policy Schedule/ Policy Certificate.
4. Eligibility
- Policy shall be offered on single trip/multi (annual) trip basis
- Premium Payment Frequency available under the policy is: Monthly/Quarterly/Half yearly/ Yearly
- Premium is payable and realized in full by the company in monthly/quarterly/half yearly frequency (as the case may be) before the installment due date.
- Area of cover
  - Worldwide, including US & Canada
  - Worldwide excluding US & Canada
  - Asia
  - Schengen Excluding US & Canada
  - Schengen Including US & Canada
  - MDV (Marhaba Dubai Visa)
For a specific group, the area of cover may be limited to any particular country or region from above list of Area of Cover.

5. Insured Person
Only those persons named as an Insured Person in the Schedule/certificate shall be covered under this Policy. Any person may be added as an Insured Person during the Policy Period after his application has been accepted by Us, additional premium to be paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

6. Waiting Period
All claims payable with respect to a Pre-Existing Illness or any conditions declared and/or accepted at the time of proposal/application will be subject to a Waiting Period as specified in the Policy Certificate.

7. Alterations and Endorsements to the Policy
This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorsement signed and stamped by Us.

The following endorsement requests can be accepted by Us:

<table>
<thead>
<tr>
<th>NO.</th>
<th>SCENARIOS</th>
<th>BEFORE POLICY START DATE</th>
<th>AFTER POLICY START DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name Change</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>2</td>
<td>Address Change</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>3</td>
<td>DOB Change</td>
<td>Allowed, subject to change in premium and company's guidelines</td>
<td>Allowed</td>
</tr>
<tr>
<td>4</td>
<td>Change of Email</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>5</td>
<td>Change of Contact number</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>6</td>
<td>Change of Risk Start and/or End Date</td>
<td>Allowed</td>
<td>Not Allowed</td>
</tr>
<tr>
<td>7</td>
<td>Trip Extension</td>
<td>Not Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>8</td>
<td>Change of Nominee</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
<tr>
<td>9</td>
<td>Change of Passport Details</td>
<td>Allowed</td>
<td>Not Allowed</td>
</tr>
<tr>
<td>10</td>
<td>Policy Cancellation</td>
<td>Allowed, only if request is received before 24 hours</td>
<td>Not Allowed</td>
</tr>
<tr>
<td>11</td>
<td>Plan Change</td>
<td>Allowed</td>
<td>Not Allowed</td>
</tr>
<tr>
<td>12</td>
<td>Geography Change</td>
<td>Allowed</td>
<td>Not Allowed</td>
</tr>
</tbody>
</table>

8. Loadings and / or exclusion
On change of your Occupation and / or risk profile, the coverage may cease, unless specifically agreed by Us. However in such case We may charge an additional loading or apply exclusion or both depending upon the risk profile.

9. Material change
The Insured/Insured Person shall immediately notify the Company in writing of any material change in the risk such as change in occupation, trip duration, country and location of travel, correction in age, nature of job and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safety and containing the circumstances that may give rise to the claim, and the Company may adjust the scope of cover and / or premium if necessary, accordingly. The liability of Company shall continue only if there is a written acceptance on the part of the Insurance through endorsement.

10. Fraudulent Claims
If any claim 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/Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy all benefits and the premium paid under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this Condition as well as under Condition No 1 of this Policy.

11. No constructive Notice
Any knowledge or information of any circumstance or condition in connection with the Insured/Insured Person in possession of any official of the Company shall not be notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

12. Notice of charge
The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured /Insured Person or his/her nominees or the legal representative, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company. In the cases of delay in the payment, the Company shall be liable to pay interest in line with the Protection of Policyholders’ Interests) Regulations, 2017. The said act is available for reference in the website of the Insurance Development Regulatory Authority of India (IRDAI)

13. Electronic Transaction:
The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms or the Company’s other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company’s terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations.
including provisions of IRDAI regulations for protection of policyholder’s interests. All conditions of section 41 prescribed necessary disclosures on terms, conditions and major exclusions shall be made known to the Insured/Insured Person; Any voice transaction shall be duly recorded, with the consent of the Insured/Insured Person and the recordings shall be maintained by or on behalf of the Company and shall be made available to the Insured/Insured Person for subsequent validation/confirmation of the Insured/Insured Person, if so required.

14. Duties of the Insured/ Insured Person on occurrence of loss

On the occurrence of any loss, within the scope of this Policy the Insured/Insured Person shall:

a. Forthwith inform the Company and file/submit a Claim Form in accordance with ‘Claim Procedure’.

b. Allow the Medical Practitioner or the Surveyor or any agent of the Company to inspect the lost/damaged properties-premises/goods as well as examine the Insured/Insured Person.

c. Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties.

d. Not to abandon the insured property/items in the premises, nor take any steps to rectify/remedy the damage before the same has been approved by the Company or any of its agents or the Surveyor.

If the Insured/Insured Person does not comply with this provision of this Clause, all benefits under this Policy shall be forfeited, at the option of the Company.

15. Right to inspect

If required by the Company, an agent/representative of the Company including a loss assessor or a Surveyor appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured/Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured/Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss or such circumstance in his possession including presenting himself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

16. Position after a claim

The Insured/Insured Person shall not be entitled to abandon any insured property whether the Company has taken possession of the same or not. As from the day of receipt of the claim amount by the Insured/Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by the amount of the compensation. In case of claims under Fire and Home Burglary Sections, the sum insured can be reinstated by payment of pro-rata premium for the unexpired period from the date of such loss to the expiry of period of insurance for the amount of such loss.

17. Condition of Average

If the property hereby insured shall at the time of loss or at the commencement of any destruction of or damage to the property by any other peril hereby insured against be collectively of greater value than the Sum Insured thereon, then the Insured shall be considered as being his own insurer for the difference and shall bear a ratable proportion of the loss accordingly. Every item, if more than one, of the Policy shall be separately subject to this condition.

18. Indemnity

The Company may at its option, if applicable reinstate, replace or repair the property or premises lost or damaged or any part thereof instead of paying the amount of loss or damage or may join with any other insurer in so doing. The Company shall not be bound to reinstate exactly or completely but only as circumstances permit and in reasonably sufficient manner. In no case shall the Company be bound to expend more in reinstatement than it would have cost to reinstate such property as it was at the time of the occurrence of such loss or damage and in any event not more than the sum Insured Person thereon. If in any case the Company shall be unable to reinstate or repair the insured property/item, because of any law or other regulations in force affecting insured property or otherwise, the Company shall, in every such case, only be liable to pay such sum as would be requisite under this Policy. However, this condition shall not be applicable to Personal Accident, Accidental Death and Permanent Total Disability – Common Carrier Sections.

19. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person’s rights or recovery thereof against any person or Organisation, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person’s indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. However, this condition shall not be applicable to Emergency Medical Expenses, Emergency Medical Evacuation, Repatriation of Mortal Remains, Dental Treatment Expenses, Personal Accident, Accidental Death and Permanent Total Disability – Common Carrier, Daily allowance in case of Hospitalization Sections.

20. Contribution

If at the time of the happening of any loss or damage covered by this Policy, there shall be existing any other insurance of any nature whatsoever covering the same, whether effected by the Insured/Insured Person or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage. However, this condition shall not be applicable to Emergency Medical Expenses, Emergency Medical Evacuation, Repatriation of Mortal Remains, Dental Treatment Expenses, Personal Accident, Accidental Death and Permanent Total Disability – Common Carrier, Daily allowance in case of Hospitalization Sections.

21. Two Policy Period (Applicable for Annual policies only)

If the claim event falls within two policy periods, the claims will be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured/Insured Person or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage. However, this condition shall not be applicable to Emergency Medical Expenses, Emergency Medical Evacuation, Repatriation of Mortal Remains, Dental Treatment Expenses, Personal Accident, Accidental Death and Permanent Total Disability – Common Carrier, Daily allowance in case of Hospitalization Sections.

22. Forfeiture of claims

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the Arbitrator or Arbitrators have made
their award, all benefits under this Policy shall be forfeited.

23. Free Look Period
The insured/insured persons have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If insured/insured persons have any objections to any of the terms and conditions, they have the option of canceling the Policy stating the reasons for cancellation and the premium paid will be refunded, after adjusting the amounts spent on stamp duty charges and proportionate risk premium.

1. Insured(s) can cancel the Policy before the commencement of the Risk Period, or
2. Insured(s) may also cancel the policy after the commencement of the Risk Period (in case of annual risk policies only) subject to no claim under the policy, in which case the premium will be returned on pro-rata basis. All the rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look provision is not applicable and available at the time of renewal and/or at the time of subsequent trips for Annual Multi Trip Policy.

24. Termination / Cancellation
In case of Annual Policies, the Company may at any time, cancel this Policy, by giving 30 days notice in writing by Registered Post Acknowledgment Due to the Insured/Insured Person at his last known address. The Company shall exercise its right to cancel only in case of mis-representation, non-disclosure of material facts. In such cases, policy shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm. The Company shall exercise its right to cancel the policy on grounds of non-cooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy. In such cases, Insurer shall be liable to repay premium as specified in the below mentioned table subject to no claims. The Insured/Insured Person may also give 30 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company’s short period scales, provided that, no refund of premium shall be made if any claim has been made under this Policy by or on behalf of the Insured/Insured Person upto the date of cancellation of this Policy.

<table>
<thead>
<tr>
<th>Policy Period</th>
<th>Rate Of Premium to be retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 15% of Policy Period</td>
<td>25% of premium paid</td>
</tr>
<tr>
<td>Up to 25% of Policy Period</td>
<td>50% of premium paid</td>
</tr>
<tr>
<td>Upto 50% of Policy Period</td>
<td>75% of premium paid</td>
</tr>
<tr>
<td>Exceeding 50% of Policy Period</td>
<td>100% of premium paid</td>
</tr>
</tbody>
</table>

In case of single trip policies, termination of the Policy at a date earlier than the end date can be done only if the Insured Person returns back to the Republic of India earlier than the end date of the Period of Insurance of the Policy. Refund of premium for the days between the return date to the Republic of India and the end date of the Period of Insurance as mentioned in the Policy Schedule/Policy Certificate will only be given if the same are a minimum of 10 days. A cancellation charge will be deducted from the refund premium. Premium refunded will be equal to the amount of premium to be paid for the original Policy duration minus the premium to be paid by taking the return date as the new end date of Period of Insurance, provided that, no refund of premium shall be made if any claim has been made under this Policy by or on behalf of the Insured/Insured Person.

25. Cause of Action
No claim shall be payable under this Policy where the cause of action arises in India, unless otherwise specifically provided in the Policy Schedule/Policy Certificate.

26. Policy Disputes
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the insured and the Company to be subject to Indian law and in Indian Court.

27. Arbitration clause
If any dispute or difference shall arise as to the quantum to be paid under this 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 thereto 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 dispute or difference shall be referable to arbitration, as hereinbefore 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 the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

28. Renewability
The Company shall give notice for renewal of the Annual Multi Trip policies and accept renewal premium in all cases except in case of fraud, misrepresentation or non-cooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy or if the renewal of Policy poses a moral hazard. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the declaration herein before mentioned and that nothing is known to the Insured/Insured Person that may result to enhance the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

This Policy provides 30 days Grace Period for renewing the Policy. However, there is no coverage for injury sustained or disease contacted during this (grace) period under this Policy. Renewal premium are subject to change with prior approval of IRDAI.

Instalment premium is not received during a 15 days grace period.

The Company may vary the renewal premium and/or benefits payable subject to approval from IRDAI and inform the same to the Insured at least 3 months prior to the date of revision and/or modification.
In the likelihood of this policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the policy.

Insured will have the option to migrate to other plan under similar travel insurance policy at the time of renewal (in case of Annual policies), provided the policy has been maintained without a break.

During currency of the policy, no change of plan or Sum Insured is allowed. The Company offer assured renewal of same plan / Sum Insured for lifelong. However in renewal of annual policies, insured can enhance up to next available sum insured slab, subject to no claim in the previous policy and Good Health Declaration.

29. Extension
The Company may in its sole and absolute discretion extend the Policy once during the Risk Period, provided that:
1. We receive the request for extension of the Policy and the applicable premium before the expiry date of the Policy Period.
2. We have received a good health and no claim declaration during the Risk Period.
3. The insured persons has not made a claim just before we receive the request for extension of the policy

The Company is under no obligation to extend the Policy or to extend the Policy on the same terms and conditions whether as to premium or otherwise.

30. Notices
Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to -

a. In case of the Insured/Insured Person, at the address specified in the Policy Schedule/Certificate.

b. In case of the Company, to the Policy issuing office of the Company.

31. Customer Service
If at any time the Insured/Insured Person require any clarification or assistance, the Insured/Insured Person may contact either the Emergency Assistance Service Provider or the Policy issuing office of the Company at its address during normal office hours.

In respect of Senior Citizens, both the Company and Emergency Service Provider have established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel

32. Multiple Policies
If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, there will not be any contribution clause (Clause 20 mentioned above) and the insured can seek settlement of claim from any insurer. However if the amount claimed is in excess of Sum Insured under a single policy, after considering the deductible and/or co-pay, insured can seek settlement of claim as per his/her choice but company shall settle the claim with contribution clause

GRIEVANCES REDRESSAL PROCEDURE
The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

• Website : www.bharti-axagi.co.in
• Email : customer.service@bharti-axagi.co.inaxa.com
• Phone : 022-6188888080-49123900
• Courier : Any of the Company's Branch office / corporate office

Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company’s branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1
In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at:

Write to : Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064
Call : 022-48815939
Email : NGRO@bharti-axa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:

Email : CGRO@bhartiaxa.com

Escalation Level 3
In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, if Policyholder/ Insured/Insured Person is not satisfied with Company’s redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsmen offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders’ interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:
In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen’s channel

32. Multiple Policies
If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, there will not be any contribution clause (Clause 20 mentioned above) and the insured can seek settlement of claim from any insurer. However if the amount claimed is in excess of Sum Insured under a single policy, after considering the deductible and/or co-pay, insured can seek settlement of claim as per his/her choice but company shall settle the claim with contribution clause

GRIEVANCES REDRESSAL PROCEDURE
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• Email : customer.service@bharti-axagi.co.inaxa.com
• Phone : 022-6188888080-49123900
• Courier : Any of the Company’s Branch office / corporate office

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Write to : Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064
Call : 022-48815939
Email : NGRO@bharti-axa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2
In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:

Email : CGRO@bhartiaxa.com

Escalation Level 3
In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, if Policyholder/ Insured/Insured Person is not satisfied with Company’s redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsmen offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders’ interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:
In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen’s channel of the Company for faster attention or speedy disposal of grievance, if any.

• Website : www.bharti-axagi.co.in
• Email : customer.service@bharti-axagi.co.inaxa.com
• Phone : 022-6188888080-49123900
• Courier : Any of the Company’s Branch office / corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company’s branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI
The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.

• Website : igms.irda.gov.in
• Email : complaints@irda.gov.in
• Toll Free Number 155255 (or) 1800 4254 732
The complaint registration form is available for download at http://www.policyholder.gov.in/uploads/CEDocuments/complaintform.pdf

**LIST OF INSURANCE OMBUDSMEN**

<table>
<thead>
<tr>
<th>OFFICE DETAILS</th>
<th>JURISDICTION OF OFFICE UNION TERRITORY, DISTRICT</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHMEDABAD - Shri/Smt....</td>
<td>Gujarat, Dadar &amp; Nagar Haveli, Daman and Diu.</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: <a href="mailto:bimalokpal.ahmedabad@ecoi.co.in">bimalokpal.ahmedabad@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td>BENGALURU - Smt. Neerja Shah</td>
<td>Karnataka</td>
</tr>
<tr>
<td>Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: <a href="mailto:bimalokpal.bengaluru@ecoi.co.in">bimalokpal.bengaluru@ecoi.co.in</a></td>
<td></td>
</tr>
<tr>
<td>BHOPAL - Shri Guru Saran Shrivastava</td>
<td>Madhya Pradesh</td>
</tr>
<tr>
<td>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: <a href="mailto:bimalokpal.bhopal@ecoi.co.in">bimalokpal.bhopal@ecoi.co.in</a></td>
<td>Chattisgarh.</td>
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<td>BHUBANESHWAR - Shri/Smt.......</td>
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<td>Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: <a href="mailto:bimalokpal.bhubaneswar@ecoi.co.in">bimalokpal.bhubaneswar@ecoi.co.in</a></td>
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<td>CHANDIGARH - Dr. Dinesh Kumar Verma</td>
<td>Punjab, Haryana, Himachal Pradesh, Jammu &amp; Kashmir, Chandigarh.</td>
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<tr>
<td>Office of the Insurance Ombudsman, S.C.O. No. 101, 102 &amp; 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: <a href="mailto:bimalokpal.chandigarh@ecoi.co.in">bimalokpal.chandigarh@ecoi.co.in</a></td>
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Fill and send the Complaint Registration Form along with any letter or enclosures, if felt necessary, by post or courier to:
General Manager
Consumer Affairs Department- Grievance Redressal Cell, Insurance Regulatory and Development Authority of India (IRDAI), Sy.No.115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad-500032
<table>
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<tr>
<th>OFFICE DETAILS</th>
<th>JURISDICTION OF OFFICE UNION TERRITORY,DISTRICT</th>
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| **CHENNAI** - Shri M. Vasantha Krishna  
Office of the Insurance Ombudsman,  
Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,  
CHENNAI – 600 018.  
Tel.: 044 - 24333668 / 24335284  
Fax: 044 - 24333664  
Email: bimalokpal.chennai@ecoi.co.in | Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry). |
| **DELHI** - Shri/Smt.......  
Office of the Insurance Ombudsman,  
2/2 A, Universal Insurance Building,  
Asaf Ali Road,  
New Delhi – 110 002.  
Tel.: 011 - 23232481/23213504  
Email: bimalokpal.delhi@ecoi.co.in | Delhi |
| **GUWAHATI** - Shri Kiriti .B. Saha  
Office of the Insurance Ombudsman,  
Jeevan Nivesh, 5th Floor,  
Nr. Panbazar over bridge, S.S. Road,  
Guwahati – 781001(ASSAM),  
Tel.: 0361 - 2632204 / 2602205  
Email: bimalokpal.guwahati@ecoi.co.in | Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura. |
| **HYDERABAD** - Shri I. Suresh Babu  
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 - 67504123 / 23312122  
Fax: 040 - 23376599  
Email: bimalokpal.hyderabad@ecoi.co.in | Andhra Pradesh, Telangana, Yanam and Part of Territory of Pondicherry. |
| **JAIPUR** - Smt. Sandhya Baliga  
Office of the Insurance Ombudsman,  
Jeevan Nidhi - II Bldg., Gr. Floor,  
Bhawani Singh Marg,  
Jaipur - 302 005.  
Tel.: 0141 - 2740363  
Email: Bimalokpal.jaipur@ecoi.co.in | Rajasthan |
| **ERNAKULAM** - Shri/Smt.......  
Office of the Insurance Ombudsman,  
2nd Floor, Pulinat Bldg.,  
Opp. Cochin Shipyard, M. G. Road,  
Ernakulam - 682 015.  
Tel.: 0484 - 2358759 / 2359338  
Fax: 0484 - 2359336  
Email: bimalokpal.ernakulam@ecoi.co.in | Kerala, Lakshadweep, Mahe-a part of Pondicherry. |
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<tr>
<th>Location</th>
<th>Details</th>
<th>Jurisdiction</th>
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<tr>
<td>KOLKATA</td>
<td>Shri/Smt.</td>
<td>West Bengal, Sikkim, Andaman &amp; Nicobar Islands.</td>
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<td>Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: <a href="mailto:bimalokpal.kolkata@ecoi.co.in">bimalokpal.kolkata@ecoi.co.in</a></td>
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<td></td>
<td>Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.</td>
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<td>Tel.: 0522 - 2231330 / 223131 Fax: 0522 - 2231310 Email: <a href="mailto:bimalokpal.lucknow@ecoi.co.in">bimalokpal.lucknow@ecoi.co.in</a></td>
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<tr>
<td>MUMBAI</td>
<td>Shri Milind A. Kharat</td>
<td>Goa, Mumbai Metropolitan Region Excluding Navi Mumbai &amp; Thane.</td>
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<td></td>
<td>Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.</td>
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<td>Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: <a href="mailto:bimalokpal.mumbai@ecoi.co.in">bimalokpal.mumbai@ecoi.co.in</a></td>
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<td></td>
<td>Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301.</td>
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<td>Tel.: 0120-2514250 / 2514252 / 2514253 Email: <a href="mailto:bimalokpal.noida@ecoi.co.in">bimalokpal.noida@ecoi.co.in</a></td>
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<td>PATNA</td>
<td>Shri/Smt.</td>
<td>Bihar, Jharkhand.</td>
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<td></td>
<td>Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006.</td>
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<td>Tel.: 0612-2689952 Email: <a href="mailto:bimalokpal.patna@ecoi.co.in">bimalokpal.patna@ecoi.co.in</a></td>
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<tr>
<td>PUNE</td>
<td>Shri/Smt.</td>
<td>Maharashtra, Area of Navi Mumbai and Thane Excluding Mumbai Metropolitan Region.</td>
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<td>N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-41312555 Email: <a href="mailto:bimalokpal.pune@ecoi.co.in">bimalokpal.pune@ecoi.co.in</a></td>
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Claims Procedure

1. In the event of an accident or sudden illness which is likely to give rise to a claim under this Policy, the Insured Person shall immediately contact the Emergency Assistance Service Provider giving details of the Policy issued to him/her. The details of phone numbers and Help Line are given in the Schedule/Certificate attached to this Policy.

2. The first call will have to be made by the Insured Person giving his/her contact number and subsequent calls will be made by the Service Provider at the contact number given by the Insured Person.

3. The Insured Person or his representative shall provide to the Emergency Assistance Service Provider maximum information about the illness, accident or occurrence as is available, as well as other information such as the Policy number etc. Emergency Assistance Service Provider shall assist the Insured Person in getting admitted in to a hospital / getting treatment from a Medical Practitioner as an outpatient.

4. Where it is not possible to make an emergency call before consulting a Medical Practitioner or going into hospital, the Insured Person shall contact the Emergency Assistance Service Provider as soon as possible. In either case, when being admitted as a patient, the Insured Person shall inform the Medical Practitioner or personnel at the hospital, the details of his/her policy coverage and shall state the details of the Emergency Assistance Service Provider and request them to contact them.

5. All necessary claim documents should be furnished to the Company/ Emergency Assistance Service Provider by the policy holder/insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons of any delay.

6. If proper intimation is given, the Emergency Assistance Service Provider shall give a benefit guarantee (cash less in-patient hospitalisation as well as outpatient treatment) to the hospital / other providers for the costs of hospitalization, transportation by emergency services, emergency evacuation, transportation home, repatriation or transportation of mortal remains and burial listed under Scope of Coverage under the Policy. These costs will be settled directly by the Emergency Assistance Service Provider on behalf of and for the account of the Company. The Insured Person shall release Medical Practitioners/hospital contacted by Emergency Assistance Service Provider from their duty not to disclose information about his/her case. 

7. In such cases, the Insured Person before his discharge from the hospital, shall fill up and sign the claim form and hand over the same to the Hospital authorities to be handed over to Emergency Assistance Service Provider. Please send the duly signed claim form along with all the documents to designated TPA within 14 days of the occurrence of the Incident. However, claims filed even beyond such period should be considered if there are valid reasons of any delay.

8. Where no information is given to Emergency Assistance Service Provider and the payment for hospital treatment / outpatient treatment has been made by the Insured Person, the reasons therefore shall have to be given by the Insured/Insured Person along with the claim form giving details of treatment and bills for expenditure to the Company OR Emergency Assistance Service Provider. After examining the facts and establishing the liability, in consultation and with the approval of the Company Emergency Assistance Service Provider will reimburse to the Insured Person the costs incurred within the Scope of Coverage of the Policy on behalf of and for the account of the Company.

9. Besides where Insured or Insured Person and Emergency Assistance Service Provider agree that even though the procedure under Claims Procedure is complied with, the claim should be settled on a reimbursement basis (in consultation and with the approval of the Company), then it will be done so accordingly.

10. With respect to Emergency evacuation or repatriation, the following services shall be arranged by the Company through the Emergency Assistance Service Provider:

   a. Transferring the Insured/Insured by air ambulance, regular airline or any other method of transport that is ascertained as being appropriate by the Emergency Assistance Service Provider and/or the Company. The method of transport and the date and time shall be decided by the Emergency Assistance Service Provider and/or the Company.

   b. If the Insured/Insured Person is admitted to a Hospital then and if in the opinion of the appointed Medical Practitioner, the medical facilities in the hospital are not suitable or adequate, the Insured/Insured Person will be evacuated to the nearest place where appropriate services are available or to his/her permanent place of residence in India.

   c. Arrangement of reasonable and necessary transport and additional accommodation costs for another person to accompany the Insured/Insured Person if it is Medically Necessary that the Insured/Insured Person be accompanied in this way; this might be a Medical Practitioner, nurse, relative, friend or colleague.

   d. In the event of death of the Insured/Insured Person due to an insured event in terms of this policy, arrangements for bringing transporting the mortal remains of the deceased back to the Republic of India or reimbursement of cost of local burial or cremation in the country where the death occurred. An official death certificate and a physician's statement giving the cause of death needs to be submitted.

The Company will not be liable in respect of the emergency evacuation or repatriation service for:

   a) Any failure to provide the emergency evacuation or repatriation service or for any delays in providing it, unless the failure or delay is caused by the negligence of the Company and/or the Emergency Assistance Service Provider

   b) Failure or delay in providing the emergency evacuation or repatriation service if:

   a. By law the overseas evacuation or repatriation service cannot be provided in the country in which it is needed; or

   b. The failure or delay is caused by any reason beyond our control including, but not limited to, strikes and flight conditions.

   c. Injury or death caused while the Insured/Insured Person is being moved unless it is caused by the negligence of the Company / Emergency Assistance Service Provider or the

IRDAI REGULATION NO 5: This Policy is subject to regulation 5 of IRDAI (Protection of Policyholder’s Interests) Regulation
negligence of anyone acting on the behalf of the Company/Emergency Assistance Service Provider.

11. Quick turnaround time shall be ensured in case the Emergency Assistance Service Provider arranges the emergency evacuation. The Company shall review and monitor the promptness and quality of the service, turnaround time and accessibility provided by the Emergency Assistance Service Provider in the interest of the policyholder and shall take due course of action based on the results of the review.

12. Claims, if any, for Total Loss of Checked-in Baggage, Personal Accident and Loss of Passport will be settled in Indian Rupees in consultation and with approval of the Company, on return of the Insured Person to India. In such cases, the claim form with details is to be submitted to the Company OR Emergency Assistance Service Provider.

13. Reimbursement of all claims by the Emergency Assistance Service Provider will be in India, in Indian Rupees at the exchange rate specified by the Reserve Bank of India, as applicable on the date the amount is billed.

14. The Company shall only be liable to indemnify if, besides proof of insurance cover, the documentary proofs required as per the claims procedure stated in the Policy, is also submitted.

15. The total loss of checked-in baggage caused by an international carrier (airlines) must be reported to the International Carriers (airlines) and a Property Irregularity Report (P.I.R) shall be obtained from them. Original report together with the ticket(s), baggage tag(s) and the claim form are to be submitted in support of a claim by the Insured Person to the Company OR Emergency Assistance Service Provider.

16. When there is an Instalment facility - if Insured Person makes a claim under the policy (applicable for annual year policy), Insured Person will be liable to pay the premium for the entire policy period in full and premium shall be realized by the Company in full, before the claim is paid or Insured Person authorizes us to deduct from claim amount due any outstanding premiums due.

17. A loss of passport must be reported to the police authorities within 24 hours of discovery of such loss and an official report obtained from the Police authorities. The original official report of the Police authorities should also be submitted along with the claim form to the Company OR Emergency Assistance Service Provider.

18. Failure to comply with the claims procedure stated above in respect of Total Loss of Checked-in Baggage and Loss of Passport, may prejudice the claim of the Insured Person.

19. Claims for reimbursement shall be submitted to the Company OR Emergency Assistance Service Provider within one month after completion of the treatment or transportation home. In the event of accidental death, the same shall be submitted within one month after transportation of mortal remains/burial.

20. The Insured and the Insured Person shall provide Emergency Assistance Service Provider / the Company on demand with any information that is required to determine the occurrence of the insured event or the scope of the Company's liability. In particular, at the request of Emergency Assistance Service Provider / the Company proof shall be furnished of the actual commencement of the trip abroad.

21. If requested to do so by Emergency Assistance Service Provider / the Company, the Insured Person and/or the Insured shall authorise Emergency Assistance Service Provider / the Company to obtain all the information considered necessary from third parties (Medical Practitioners, dentists, alternative practitioners, medical institutions of any kind, insurance carriers, health or pension offices) and release these parties from their obligation not to disclose information.

22. If requested to do so by Emergency Assistance Service Provider / the Company, the Insured Person is obliged to undergo a medical examination by a Medical Practitioner designated by Emergency Assistance Service Provider / the Company.

23. In case of any claim under Personal Liability or Bail Bond proof of judicial decision rendered by a Court of Law may be required.

24. In case of any accident giving rise to a claim under the Personal Accident section of the Policy, the Insured/ Insured Person, his/her nominee or legal representatives, as the case may be, shall provide complete information and details about the Insured Person in the claim form along with the following documents to the Company OR Emergency Assistance Service Provider. Such a claim will be settled only in India in Indian rupees.

25. The Company shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provision of regulation 27 of IRDAI (Health Insurance) Regulations, 2016. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

CLAIMS:
For all queries relating to Insurance covers or to report a claim you could call Bharti Assist Global Private Limited Helpline No 844- 691-8883 (For Canada), 844-691-8885 (For USA) or +91 120 4593503 (For other parts of the world) The Card member needs to report the claim within 20 days of the occurrence of the loss. Benefits will be payable upon receipt of due written proof, as required by Bharti AXA General Insurance Company Pvt. Ltd. Company Limited for the specific claim being made, of legitimate covered loss. The benefits will be paid to the insured's nominee(s) and if no person has been nominated, then to the legal heirs of the insured. For an overview of the documents, which need to be furnished to Bharti AXA General Insurance Company Limited along with your claim, please refer to the table below:
**LIST OF DOCUMENTS REQUIRED FOR CLAIMS PROCESSING:**

### EMERGENCY MEDICAL EXPENSES

1. Claim form duly filled and signed along with attending Medical Practitioner statement
2. Copy of Policy certificate
3. Covering letter detailing circumstances
   - Medical reports and discharge summary issued by the hospital or prescriptions and medical records from the medical practitioner furnishing the name of the insured, period of treatment and details of treatment rendered i.e. line of treatment and final diagnosis.
4. Original hospital bills with proper description of services rendered and payment receipts towards expenses incurred
5. Name, Address and Phone number of the local medical officer/family physician in India.
6. Copy of Air tickets and boarding passes for the sector travelled
7. Copy of passport, visa with entry and exit stamp
8. And any other document as may be appropriately applicable for the claims preferred under this section of the Policy
9. Cancelled cheque of the insured / nominee

### TOTAL LOSS OF CHECKED IN BAGGAGE

1. Duly filled and completed claim form
2. Policy Certificate
3. Air tickets along with boarding passes
4. Copy of passport with exit and entry stamps
5. Copy of baggage tag's
6. Property Irregularity Report issued by the common carrier mentioning the number of baggage's checked-in.
7. Original Certificate from airline authorities stating that baggage has been lost along with compensation details
8. Adequate proof of ownership of items contained within checked-in baggage valued in excess of Indian rupee equivalent of US$100
9. Covering letter detailing circumstances
10. Cancelled cheque of the insured / nominee

### DELAY OF CHECKED IN BAGGAGE

- Duly filled and completed claim form
- Policy Copy
- Copy of passport, visa with entry and exit stamp
- Air tickets and boarding pass
- Property Irregularity Report issued by the common carrier.
- Certificate from airline authorities clearly stating the date and time of delay and delivery of the baggage.
- Original bills towards toiletries, medication and clothing during the delay period
- Letter/communication clearly stating the compensation details offered by the Airlines/Third Party
- Covering letter detailing circumstances
- Cancelled cheque of the insured / nominee

### LOSS OF PASSPORT AND DOCUMENTS

1. Duly filled and completed claim form 59 Internal
2. Policy Copy
3. FIR/Copy of police report mentioning the reason of loss
4. Bills/receipts of expenses incurred in obtaining a fresh/duplicate passport and other related expenses
5. Copy of new passport/driving licence and previous passport/travel documents (if available).
6. Details providing the proof for loss of debit/credit / forex card letter from bank for card block.
7. Last transaction details and transaction details prior loss of card, bank statement.
8. Air Ticket, Boarding passes and copy of passport with visa entry and exit stamp
9. Covering letter detailing circumstances
10. Cancelled cheque of the insured / nominee
11. Any other documents as required while processing the claim
1. Claim Form – completed and signed by the Insured.
2. Copy of policy Certificate,
3. Copy of complete schedule itinerary for all the sectors.
4. Copy of new itinerary in case trip got reschedule along with boarding passes.
5. Copy of Passport with visa entry and exit stamp.
6. Copies of reimbursement statements issued by an airline carrier, airport facility, car rental agency, travel agent, hotel/ motel or other similar establishment or any insurance company providing reimbursement to you for the loss.
7. All original bills and receipts for expenses which got forfeited, non-refundable in nature.
8. All original bills and receipts for additional reasonable and necessary transportation expenses and accommodation charges due to interruption of schedule flight.
9. Depending upon the peculiarity of the case, additional documents/information will be asked for.

Policy Wordings
Group Personal Accident

Preamble & Operative Clause
Bharti AXA General Insurance Company Limited will provide insurance cover to the person(s) named in the Schedule based on the material facts recorded in the proposal and declaration made and agreed premium has been paid and realized by us in full. We will pay the insured person(s) in respect of an insured event occurring during the policy period and subject to the Conditions, Sum Insured, Scope of Coverage, Territorial Limits, Endorsement, Deductible and Exclusions in the manner and to the extent set forth in this policy.

Definitions
Any words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy or Schedule. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

“Aadhaar” means Aadhar Card.

“Accident” means sudden, unforeseen and involuntary event caused by external, visible and violent means.

“Any One Accident (AOA)” means the maximum amount payable by the Company in respect of any single Accident, irrespective of the number of insured Persons involved in such Accident. In the event that an Accident occurs which results in insurable losses under this Policy and which ordinarily would mean that the AOA limit is exceeded, the AOA Limit amount will be distributed on a proportional basis to all Insured Persons, taking into account the maximum Sums Insured per Benefit and per Insured Person.

“Any One Year (AOY)” means the maximum amount payable under the benefit as specified in the Policy Schedule in respect of all claims by or on behalf of all Insured Persons, if at any time the total value of unpaid claims would, if paid, result in this AOY limit being exceeded, the individual benefits attributable to those outstanding claims shall be reduced pro rata as necessary to ensure that this maximum AOY limit is not exceeded.

“Company/We/Our/Ours” means Bharti AXA General Insurance Company Limited.

“Condition Precedent” means a policy term or condition upon which the Insurer’s liability under the policy is conditional upon.

“Congenital Anomaly” means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly-Congenital anomaly which is not in the visible and accessible parts of the body.

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

“Co-payment” means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

“Day care treatment” means medical treatment, and/or surgical procedure which is:

a. undertaken under General or Local Anesthesia in a hospital / day care centre in less than 24 hours because of technological advancement, and

b. which would have otherwise required hospitalization of more than 24 hours.

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

“Deductible” means a cost sharing requirement under a health insurance policy that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

“Dependent Child” means a natural or legally adopted child, aged between 91 days to 23 Years and pursuing full time education and financially dependent on the Primary Insured.

“Endorsement” means a policy term or condition upon which the Insurer’s liability under the policy is conditional upon.

“Emergency care” means management for an 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.

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

a. has qualified nursing staff under its employment round the clock;

b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other
places;
c. has qualified medical practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

“Hospital” outside India shall mean an institution established for the treatment of patients which is under constant medical management, has adequate diagnostic and therapeutic facilities, keeps constant medical records, is recognized as a hospital in the country in which it is situated, and which is appropriately licensed, wherever required to be so, to operate as a hospital in that country.

“Hospitalization” means admission in a Hospital for a minimum period of 24 consecutive ‘in-patient’ hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

“ICU (Intensive Care Unit) 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.

“Illness” means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests

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

iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. it continues indefinitely

v. it recurs or is likely to recur

“Immediate Family Members” shall mean Married spouse, Children (Biological or Legally Adopted), Parents & Siblings.

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

“Inpatient care” means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

“Insured Person(s)/You/Your” means the person(s) named in the Schedule/Certificate of Insurance.

“Intensive care unit (ICU)” 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.

“Maternity expenses” means;
a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b. expenses towards lawful medical termination of pregnancy during the policy period.

“Medical Advice” means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

“Medical Expenses” means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of 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.

“Medically necessary treatment” means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

a. is required for the medical management of the injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a medical practitioner;
d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

“Medical Practitioner” means a person who holds a valid registration from the Medical Council of any State 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 thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

The registered practitioner should not be the insured or close member of the family.

“Newborn baby” means baby born during the Policy Period and is aged up to 90 days.

“No notification of claim” means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

“OPD 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.

“Policyholder” means an Individual/Organisation/Association in whose name the policy has been issued and should have an insurable interest to cover the insured person(s) under the policy.

“Policy Period” means the period between the inception date and the expiry date specified in the Schedule. Policy period can be less than 1 Year, 1/2/3/4/5 year(s) in context of this policy.

“Policy Schedule” means the document attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

“Pre-Existing Condition” means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice
and/or were diagnosed, and/or for which medical advice means any condition, ailment or injury "Policy Schedule" be less than 1 Year, 1/2/3/4/5 year(s) in context of this policy. and the expiry date specified in the Schedule. Policy period can means the period between the inception date "Policy Period" insurable interest to cover the insured person(s) under the policy. Practitioner. The Insured is not admitted as a day care or "Notification of claim" "Newborn baby" means baby born during the Policy Period and member of the family. The registered practitioner should not be the insured or close "Medical Practitioner" community in India. Must conform to the professional standards widely accepted adequate and appropriate medical care in scope, duration, or b. a. charged for the same medical treatment. to the insurer or TPA through any of the recognized modes of "Medical Advice" during the policy period. b. complicated deliveries and caesarean sections incurred during medical treatment expenses traceable to childbirth (including a. "Maternity expenses" means; b. is required for the medical management of the injury suffered its jurisdiction; and is acting within its scope and jurisdiction of registration from the Medical Council of any State or Medical "Medical Practitioner" means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy. "Subrogation" means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source. "Sum Insured" means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period. "Surgery or Surgical Procedure" means manual and/or operative procedure (s) required for treatment of an injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner. "Unproven/Experimental treatment" means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

SCOPE OF COVER The Policy intends to offer optional coverage chosen by the Policyholder, Endorsed by the Company upon payment and realization of agreed premium in full and specified under the policy schedule.

GENERAL EXCLUSIONS The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following: ● Any Pre-existing Condition(s) and complications arising out of or resulting therefrom; ● Through suicide, attempted suicide (whether sane and insane) or intentionally self-inflicted injury or illness, including abstinent from a normal behavior of having food. ● Mental or nervous disorder, anxiety, or depression, ● Whilst engaging in Adventure Sports. The list of adventurous sports are Water Rafting, Wildlife/Jeep Safaris, Trekking, Camping, Boat safaris, Parasailing, Paragliding, Elephant/Camel/Horse/Yak Safaris, Cycling, House Boat stays, Motor Bike tours, Kayaking, Rock Climbing, Artificial Wall Climbing, Bungee Jumping, Paintball, Suba Diving, Hot Air Ballooning, Canoeing, Mountain Biking, Rappelling, Snorkeling, Zip wires & high Rope course, Abseiling, Surfing, Water Skiing, Skiing, Caving, Self-Drive tours, Mountaineering/Hiking, All Terrain Vehicle, Hang Gliding, Snowboarding, Ultra-Light flying, Heli-skiing, Sky Diving. ● While under the influence of liquor or drugs, alcohol or other intoxicants, ● Through deliberate or intentional, unlawful or criminal act, error, or omission, participation in an actual or attempted felony, riot, crime, misdemeanor, civil commotion, ● Whilst engaging in aviation, whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world, ● Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs, ● As a result of any curative treatments or interventions that you carry out or have carried out on your body, including alternative forms of medicines like chiropractic treatments etc. ● Arising out of your participation in any police, naval, military or air force operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy. Whether foreign or domestic, ● Your consequential losses of any kind or your actual or alleged legal liability. ● Venereal or sexually transmitted diseases, ● HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or mutant derivatives or variations thereof however caused, ● Pregnancy, resulting childbirth, maternity expenses, miscarriage, abortion, or complications arising out of any of these, ● War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority, or ● Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel, ● The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment, ● Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines ● No benefit would be paid under this policy, unless the nature & extent of injury is established medically with appropriate investigation reports & certified by the treating doctor ● While engaged in hazardous activity unless specifically covered under the policy, ● Expenses incurred on neck belts, wrist bandages, walking sticks, abdomen belts, CPAP and any other similar external aid/devices, the use of which has been necessitated following an accident unless specifically covered under the policy.

ADDITIONAL EXCLUSIONS APPLICABLE TO THE MEDICAL SECTIONS
I. CONSIDERATION:
The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be made annually or on installment basis.

II. OBSERVANCE OF TERMS AND CONDITIONS:
The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Policyholder/Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

III. MATERIAL CHANGE:
The Policyholder/Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Policyholder’s/Insured person’s own expense. The Company may, adjust the scope of cover and/or the premium, if necessary, accordingly.

IV. FRAUDULENT CLAIMS:
If any claim 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 Policyholder/Insured Person or anyone acting on their behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this condition as well as Duty of Disclosure condition of this Policy.

V. NO CONSTRUCTIVE NOTICE:
The Company shall not take notice of any information relating to the Policyholder/Insured person unless such information is submitted in writing by the Policyholder/Insured person, even if such information was available with the Company.

VI. NOTICE OF CHARGE:
The Company is not under obligation to take notice of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured Person or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

VII. SPECIAL PROVISIONS:
Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

VIII. ELECTRONIC TRANSACTION:
The Policyholder/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web,
The Casualty Section. The Company shall pay up to the highest
Casualty Section, the liability of the Company shall be restricted
and there are admissible claims under multiple benefits of the
If due to any single accident, any Insured person sustains injury
amount.

Policyholder, the days Insured for the remainder of the Policy
As from the day of receipt of the claim amount by the
Company under this Policy.

Company to ascertain the correctness thereof or the liability of
Company so far as they relate to such claims or shall assist the
in presenting himself/herself for examination and furnish copies of
documents relating to or containing reference relating to the
leading to claim. The Insured Person or his representatives shall
On being required so to do by the Company produce all relevant
documents relating to or containing reference relating to the
loss/event or such circumstance in his/her possession including

- Forthwith file/submit a claim form in accordance with “Claim
Procedure” clause.
- Allow the Medical Practitioner or any representative of the
Company to inspect the medical and hospitalization records and
to examine the Insured Person
- Assist and not hinder or prevent the Company or any of its
representatives in pursuance of their duties
In case the Policyholder/Insured Person does not comply with
the provisions of this clause or other obligations cast upon the
Policyholder/Insured Person under this Policy or in any of the
Policy documents, all benefit under the Policy shall be forfeited,
at the option of the Company.

X. RIGHT TO INVESTIGATE:
If required by the Company, an agent/representative of the
Company including a physician appointed in that behalf in case
of any loss/event/claim or any circumstances that have given rise
to a claim to the Insured Person, be permitted at all reasonable
times to investigate into the circumstances of such loss/event
leading to claim. The Insured Person or his representatives shall
on being required so to do by the Company produce all relevant
documents relating to or containing reference relating to the
loss/event or such circumstance in his/her possession including
presenting himself/herself for examination and furnish copies of
or extracts from such of them as may be required by the
Company so far as they relate to such claims or shall assist the
Company to ascertain the correctness thereof or the liability of
the Company under this Policy.

The Company shall bear all cost of investigation required under
this section.

XI. POSITION AFTER A CLAIM:
As from the day of receipt of the claim amount by the
Policyholder, the days Insured for the remainder of the Policy
year of insurance shall stand reduced by a corresponding
amount.
If due to any single accident, any Insured person sustains injury
and there are admissible claims under multiple benefits of the
Casualty Section, the liability of the Company shall be restricted
to the highest Sum Insured specified under any one benefit of the
Casualty Section. The Company shall pay up to the highest
Sum Insured under any one benefit less any other amount
already paid or payable under any benefits of Casualty as opted
by the Policyholder and offered under this Policy, as the result of
the same accident.

In the event of multiple accidents during the policy period
resulting in claim in one or more than one section, the liability of
the company shall be restricted to the highest amount payable in
each of the section claimed against.
The policy shall terminate from the date of payment of claim and
all the covers/benefits under Casualty, Medical & Add-On
sections shall cease from the date of loss, in the event of an
admissible Accidental Death or Disappearance claim paid under
the policy.
The Company’s liability for claims shall be limited to the AOA &
or AOY limit if the same has been opted by the Policyholder and
specified in the Policy Schedule/Certificate of Insurance.

XII. MULTIPLE POLICIES:
If two or more policies are taken by an insured during a period
from one or more insurers to indemnify treatment costs, the
policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

- In all such cases the insurer who has issued the chosen policy
shall be obliged to settle the claim as long as the claim is within
the limits of and according to the terms of the chosen policy.

- Claims under other policy/ies may be made even if Sum Insured
is not exhausted in the earlier chosen policy/policies for the
disallowed amounts under the earlier chosen policy/policies.

- If the amount to be claimed exceeds the sum insured under a
single policy after considering the deductibles or co-pay, the
policyholder shall have the right to choose insurers from whom
he/she wants to claim the balance amount.

- Where an insured person has policies from more than one
insurer to cover the same risk on indemnity basis, the insured
shall only be indemnified the hospitalization costs in accordance
with the terms and conditions of the chosen policy.

The points mentioned above shall not apply for claims payable on Benefit basis.

XIII. FORFEITURE OF CLAIMS:
If any claim is made and rejected and no court action or suit is
commenced within 12 months after such rejection or, in case of
arbitration taking place as provided therein, within 12 calendar
months after the arbitrator or arbitrators have made their award,
all benefits under this Policy shall be forfeited and will not have
any rights whatsoever.

XIV. FREE LOOK PERIOD:
Insured/ Policyholder has a period of 15 days from the date of
receipt of the Policy document/Certificate of Insurance to review
the terms and conditions of this Policy/Certificate of Insurance. If the
Insured/ Policyholder has any objections to any of the terms
and conditions, he/she have the option of cancelling the
Policy/Certificate of Insurance stating the reasons for
cancellation and in such a case, the Company will refund
premium subject to:

- A deduction of the expenses incurred on stamp duty charges,
if the risk has not commenced.

- A deduction of the expenses incurred on stamp duty charges

and proportionate risk premium for period on cover, if the risk has commenced. A deduction of such proportionate risk premium in commensuration with the risk covered during such period, where only a part of risk has commenced.

The Policy can be cancelled only if there is no claim under the Policy. Free look provision is not applicable and/or available at the time of renewal of the Policy.

XV. CANCELLATION:
Single Policy/Master Policy
The Company may cancel this Policy, by giving 15 days' notice in writing/e-mail registered with us acknowledgment due to the Policyholder at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts, in which case the policy shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm. In case of non-cooperation of the Policyholder in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy.

The Policyholder may also give 15 days' notice in writing/ e-mail registered with us, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice, cancel the Policy and retain the premium for the period this Policy has been in force as opted for by the Policyholder and mentioned in the Renewal & Refund section of this Policy. Provided that, refund on cancellation of Policy by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Policy.

The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier.

CERTIFICATE OF INSURANCE
Each Certificate of Insurance will terminate on the earliest of the following dates:

1. The date the master Policy is terminated,
2. The date insured person or Company cancel the Certificate of Insurance.
3. The date the Insured person ceases to be part of the group unless specified otherwise.
4. The date of Expiry of the Certificate
5. Instalment premium is not received during a 15 Days Grace period.

The Company may cancel this Certificate of Insurance, by giving 15 days' notice in writing/ e-mail acknowledgment due to the Insured at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation fraud, non-disclosure of material facts of the Insured/ Insured Person in which case the Certificate of Insurance shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm.

In case of non-cooperation of the Insured/Insured Person(s) in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy.

The Insured may also give 15 days’ notice in writing, to the Company, for the cancellation of this Certificate of Insurance, in which case the Company shall from the date of receipt of notice, cancel the Certificate of Insurance and retain the premium for the period this Certificate of Insurance has been in force, as opted for by the Policyholder and mentioned in the Renewal & Refund section of this Policy. Provided that, refund on cancellation of Certificate of Insurance by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Certificate of Insurance.

XVI. TERRITORIAL LIMITS/CURRENCY OF PAYMENT:
The coverage under each of the sections of the policy shall be restricted to the Territorial limits as specified in the Schedule. All claims shall be payable in India in Indian Rupees only.

XVII. POLICY DISPUTES:
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Policyholder and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

XVIII. ARBITRATION (FOR INDEMNITY CLAIMS):
If any dispute or difference shall arise as to the quantum to be paid under this 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 to the dispute/difference, 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 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996 and amendments as applicable.

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

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

XIX. RENEWAL & REFUND:
The premium for renewal will be applicable as per the premium quote issued by the company based on age; Sum Insured; Change in group size, past policy claims history and any other relevant factors affecting the risk of the group.

In the likelihood of this Policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the Policy. Insured will have the option to
migrate to other plan under similar health insurance Policy at the
time or renewal, provided the Policy is maintained without a
break.

All applications for renewal of the Policy must be received by us
before the expiry of current Policy.

REFUND: As opted for by the Policyholder and indicated in the
Master Policy refund will be done in the following proportion:

<table>
<thead>
<tr>
<th>Period on risk</th>
<th>% Return Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 1 month</td>
<td>3/4th of the annual rate</td>
</tr>
<tr>
<td>Upto 3 months</td>
<td>½ of the annual rate</td>
</tr>
<tr>
<td>Upto 6 months</td>
<td>1/4th of annual rate</td>
</tr>
<tr>
<td>Exceeding 6 months</td>
<td>Nil</td>
</tr>
</tbody>
</table>

MULTI-YEAR POLICY – APPLICABLE FOR MULTIYEAR POLICY

<table>
<thead>
<tr>
<th>Loan Period(Year)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5/5+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Period (Year)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Year Of Cancellations</td>
<td>Rate of Premium to be Return (%) to Insured</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>50%</td>
<td>67%</td>
<td>75%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>33%</td>
<td>50%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>25%</td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>NIL</td>
<td></td>
</tr>
</tbody>
</table>

In event of part prepayment of the Loan, no refunds of premium
shall be made under this Policy. No refunds of premium will be
made under the Policy during the last year of the Policy Period.
In event of prepayment of the entire Loan and upon making any
refund of premium under this Policy in accordance with the
terms and conditions hereof in respect of the Insured Person, the
cover in respect of the Insured Person shall forthwith terminate
and the Company shall not be liable hereunder. Notwithstanding
anything contained herein or otherwise, no refunds of premium
shall be made in respect of the Insured Person where any claim
has been admitted by the Company or has been lodged with the
Company.

XX. INCLUSION OF MEMBERS UNDER THE POLICY:
New Person can be added to this Policy, either by way of
endorsement in case of mid-term inclusion or at the time of
renewal subject to acceptance by the Company.

XXI. RENEWAL NOTICE:
The Company shall not be bound to accept any renewal premium
or to give notice that such is due.

XXII. ENTRY AGE:
The minimum entry age under the policy is 91 days. The
Maximum entry age shall be restricted to 85 Years.

XXIII. NOTICES:
Any notice, direction or instruction given under this Policy shall
be in writing and delivered by hand, post or facsimile to;

● In case of the Policyholder/Insured Person, at the address given
in the Schedule to the Policy/Certificate of Insurance.

● In case of the Company, to the Policy issuing office/nearest
office of the Company.

SECTION 5: GRIEVANCES REDRESSAL PROCEDURE
The Company is committed to extend the best possible services
to its customers. However, If Policyholder/Insured Person have a
grievance that he/she wish us to redress, he/she may contact the
Company with the details of their grievance via:

● Website: www.bharti-axagi.co.in
● Email: customer.service@bharti-axa.com
● Phone: 022-61188888
● Courier: Any of the Company’s Branch office or corporate
office Policyholder/Insured/ Insured Person may also approach
the grievance cell at any of the Company’s branches with the
details of the grievance during working hours from Monday to
Friday.

ESCALATION LEVEL 1
In case the Policyholder/Insured/Insured Person has not got
his/her grievances redressed through one of the above methods
(After 5 days of intimating of your complaint), Policyholder/
Insured/ Insured Person may contact the National Grievance
Redressal Officer at:

Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd
floor, Malad Link Road, Malad (west), Mumbai- 400064
Call: 022-48815939
Email: NGRO@bharti-axa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

ESCALATION LEVEL 2
In case the Policyholder/ Insured/Insured Person has not got
his/her grievances redressed through any of the above methods
(After 5 days of approaching National Grievance Redressal
Officer), Policyholder/ Insured/ Insured Person may contact the
Chief
Grievance Redressal Officer at:
Email: CGRO@bharti-axa.com

ESCALATION LEVEL 3
In case the Policyholder/ Insured/Insured Person has not got
his/her grievances redressed by the Company within 14 days, or,
if Policyholder/ Insured/Insured Person is not satisfied with
Company’s redressal of the grievance through one of the above
methods, Policyholder/ Insured/ Insured Person may approach
the nearest Insurance Ombudsman for resolution of their
grievance. The contact details of Ombudsman offices are
mentioned below. Policy holder may also obtain copy of IRDAI
Circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on
Insurance Regulatory and Development Authority (Protection of
Policy holders’ interests) Regulations, 2017 from any of our
offices.
Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen’s channel of the Company for faster attention or speedy disposal of grievance, if any.
- Website: www.bharti-axagi.co.in
- Email: customer.service@bhartiaxa.com
- Phone: 022-61188888
- Courier: Any of the Company’s Branch office or corporate office

Insured/Insured Person may also approach the grievance cell at any of the Company’s branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.
- Website: igms.irda.gov.in
- Email: complaints@irda.gov.in
- Toll Free Number 155255 (or) 1800 4254 732

Fill and send the Complaint Registration Form along with any letter or enclosures, if felt necessary, by post or courier to:

General Manager
Consumer Affairs Department- Grievance Redressal Cell,
Insurance Regulatory and Development Authority of India(IRDAI),
Sy.No.115/1,Financial District, Nanakramguda,
Gachibowli, Hyderabad-500032

The Compliant Registration Form is available for download at http://www.policyholder.gov.in/uploads/CEDocuments/complaintform.pdf

LIST OF INSURANCE OMBUDSMEN

<table>
<thead>
<tr>
<th>Office of the insurance ombudsman, Ahmedabad</th>
<th>Office of the insurance ombudsman, Bhubaneswar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeevan prakash building, 6th floor, Tilak marg, relief road, Ahmedabad - 380 001. Tel: 079 - 25501201/02/05/06 Email: <a href="mailto:bimalokpal.ahmedabad@gbic.co.in">bimalokpal.ahmedabad@gbic.co.in</a></td>
<td>Office of the insurance ombudsman, 62, forest park, Bhubneshwar – 751 009. Tel: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: <a href="mailto:bimalokpal.bhubaneswar@gbic.co.in">bimalokpal.bhubaneswar@gbic.co.in</a></td>
</tr>
<tr>
<td>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: <a href="mailto:bimalokpal.bhopal@gbic.co.in">bimalokpal.bhopal@gbic.co.in</a></td>
<td></td>
</tr>
<tr>
<td>Office of the insurance ombudsman, S.c.o. no. 101, 102 &amp; 103, 2nd floor, Batra building, sector 17 – d, Chandigarh – 160 017. Tel: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: <a href="mailto:bimalokpal.chandigarh@gbic.co.in">bimalokpal.chandigarh@gbic.co.in</a></td>
<td>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: <a href="mailto:bimalokpal.chennai@gbic.co.in">bimalokpal.chennai@gbic.co.in</a></td>
</tr>
<tr>
<td>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: <a href="mailto:bimalokpal.delhi@gbic.co.in">bimalokpal.delhi@gbic.co.in</a></td>
<td>Office of the insurance ombudsman, Jeevan nivesh, 5th floor, Nr. Panbazar over bridge, s.s. road, Guwahati – 781001(assam). Tel: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: <a href="mailto:bimalokpal.guwahati@gbic.co.in">bimalokpal.guwahati@gbic.co.in</a></td>
</tr>
<tr>
<td>Office of the insurance ombudsman,</td>
<td>Office of the insurance ombudsman,</td>
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<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>6-2-46, 1st floor, “moin court”.</td>
<td>Jeevan nidhi – ii bldg., gr. Floor,</td>
</tr>
<tr>
<td>Lane opp. Saleem function palace,</td>
<td>Bhawani singh marg,</td>
</tr>
<tr>
<td>A. C. Guards, lakdi-ka-pool,</td>
<td>Jaipur - 302 005.</td>
</tr>
<tr>
<td>Hyderabad - 500 004,</td>
<td>Tel: 0141 - 2740363</td>
</tr>
<tr>
<td>Tel: 040 - 65504123 / 23312122</td>
<td>Email: <a href="mailto:bimalokpal@gbic.co.in">bimalokpal@gbic.co.in</a></td>
</tr>
<tr>
<td>Fax: 040 - 23376599</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:bimalokpal.hyderabad@gbic.co.in">bimalokpal.hyderabad@gbic.co.in</a></td>
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<table>
<thead>
<tr>
<th>Office of the insurance ombudsman,</th>
<th>Office of the insurance ombudsman,</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd floor, pulimat bldg.,</td>
<td>Hindustan bldg. Annexe, 4th floor,</td>
</tr>
<tr>
<td>Opp. Cochin shipyard, m. G. Road,</td>
<td>4, c.r. avenue,</td>
</tr>
<tr>
<td>Ernakulam - 682 015.</td>
<td>Kolkata - 700 072.</td>
</tr>
<tr>
<td>Tel: 0484 - 2358759 / 2359338</td>
<td>Tel: 033 - 22124339 / 22124340</td>
</tr>
<tr>
<td>Fax: 0484 - 2359336</td>
<td>Fax: 033 - 22124341</td>
</tr>
<tr>
<td>Email: <a href="mailto:bimalokpal.ernakulam@gbic.co.in">bimalokpal.ernakulam@gbic.co.in</a></td>
<td>Email: <a href="mailto:bimalokpal.kolkata@gbic.co.in">bimalokpal.kolkata@gbic.co.in</a></td>
</tr>
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<tr>
<th>Office of the insurance ombudsman,</th>
<th>Office of the insurance ombudsman,</th>
</tr>
</thead>
<tbody>
<tr>
<td>6th floor, jeevan bhawan, phase-ii,</td>
<td>3rd floor, jeevan seva annexe,</td>
</tr>
<tr>
<td>Nawal kishore road, hazratganj,</td>
<td>S. V. Road, santacruz (w),</td>
</tr>
<tr>
<td>Lucknow - 226 001.</td>
<td>Mumbai - 400 054.</td>
</tr>
<tr>
<td>Tel: 0522 - 2231330 / 2231331</td>
<td>Tel: 022 - 26106552 / 26106960</td>
</tr>
<tr>
<td>Fax: 0522 - 2231310</td>
<td>Fax: 022 - 26106052</td>
</tr>
<tr>
<td>Email: <a href="mailto:bimalokpal.lucknow@gbic.co.in">bimalokpal.lucknow@gbic.co.in</a></td>
<td>Email: <a href="mailto:bimalokpal.mumbai@gbic.co.in">bimalokpal.mumbai@gbic.co.in</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office of the insurance ombudsman,</th>
<th>Office of the insurance ombudsman,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeevan darshan bldg., 3rd floor,</td>
<td>1st floor,kalpana arcade building,,</td>
</tr>
<tr>
<td>C.t.s. no.s. 195 to 198,</td>
<td>Bazar samiti road,</td>
</tr>
<tr>
<td>N.c. kelkar road, narayan peth,</td>
<td>Bahadurpur,</td>
</tr>
<tr>
<td>Tel: 020-41312555</td>
<td>Tel: 0612-2680952</td>
</tr>
<tr>
<td>Email: <a href="mailto:bimalokpal.pune@gbic.co.in">bimalokpal.pune@gbic.co.in</a></td>
<td>Email: <a href="mailto:bimalokpal.patna@gbic.co.in">bimalokpal.patna@gbic.co.in</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office of the insurance ombudsman,</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhagwan sahai palace</td>
<td></td>
</tr>
<tr>
<td>4th floor, main road,</td>
<td></td>
</tr>
<tr>
<td>Naya bans, sector 15,</td>
<td></td>
</tr>
<tr>
<td>Distt: gautam buddh nagar,</td>
<td></td>
</tr>
<tr>
<td>U.p-201301.</td>
<td></td>
</tr>
<tr>
<td>Tel: 0120-2514250 / 2514252 / 2514253</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:bimalokpal.noida@gbic.co.in">bimalokpal.noida@gbic.co.in</a></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 6: CLAIM SERVICING:**

I. Claim Notification - Multi Model Intimation:

- Toll Free call Centre of the Insurance Company (24x7) - 1800-103-2292
- Login to the Company’s website and intimate the claim – http://www.bharti-axa.com/content-us
- Send an email to the Company - claims@bharti-axa.com or BAGIClaims.Commercial@bharti-axa.com
- Post/courier to the Company - Bharti AXA General Insurance Company Limited, 3rd floor, Spectrum Tower, Rajan Pada, Mindspace, Malad (W), Mumbai - 400 064

In all the above, the intimations are directed to a central team for prompt and immediate action.

II. Information Details

- Insured Person/Insured Person’s representative should intimate the claims within 7 working days upon occurrence of the event. For emergency hospitalization claims, the Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured Person or his representative. In the event Insured Person is unwell, then the Notification of Claim should be provided by Insured Person’s representative.

However, if there is a genuine reason for delay in intimation, the Company shall not enforce any penalty if the admissibility of the claims is not contested upon.

When the Insured Person/Insured Person’s representative
intimates a claim as mentioned above the following information should be given for prompt services.
- Aadhar Card No.
- Master Policy number
- Certificate number
- Name of the Policyholder
- Name of Insured Person making the claim
- Contact details
- Nature of the Injury
- Name and address, phone number of the attending medical practitioner/hospital.
- Date of hospitalization

III. Claim Form
Upon the notification of the claim, The Company shall assist the Insured person/Insured Person’s nominee/legal heir to access the claim form electronically through web download, email or visit to the nearest branch of the Company. Alternatively, the Company will dispatch the claim form to the Insured person/Insured Person’s nominee/legal heir.

IV. Claim Procedure
- The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received in full and all payments have been realized.
- The Company will only make payment as per the Policyholder’s direction. In case of Insured Person’s unfortunate demise, the Company will only make payment to the Assignee or Nominee (as named in the Policy Schedule/Certificate of Insurance).
- When there is an Instalment facility - if Insured Person makes a claim under the policy (applicable for both annual and multi-year policy), Insured Person will be liable to pay the premium for the entire policy period in full and premium shall be realized by the Company in full, before the claim is paid or Insured Person authorizes us to deduct from claim amount due any outstanding premiums due.
- The Company is not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
- The Company will process the claims and make claim payments.
- If there is any deficiency in the documents/information submitted by Insured person, the Company will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents to the Company’s satisfaction, the Company will settle or reject a claim, as may be the case, within thirty days of the receipt of the last ‘necessary’ document.

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the offer of settlement/intimation of rejection with reasons will be made to the Insured in any case not later than 30 days maximum. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid. The period of 7 days mentioned above is included in the maximum period of claim settlement (30 days) stated above.

V. Documents
It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

VI. Repudiations
The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. For Reimbursement Claims:
- If original bills, receipts, prescriptions, reports and other documents are submitted to the Company and Insured Person requires same for claiming amount from other organization/provider (which is otherwise not payable under our policy), then on request from the Insured Person, We will provide attested copies of the bills and other documents submitted by the Insured Person.
- In the event of the original documents being provided to any other insurance Company/Reimbursement provider, The Company shall accept verified photocopies of such documents attested along with the settlement letter by such other insurance Company/reimbursement provider.

ENDORSEMENTS – OPTIONAL COVERS
It is hereby agreed that subject to the terms & conditions, exclusions under the policy, any endorsements issued with this policy shall modify the scope of coverage to the extent as specified in the endorsement wording. The Company’s liability arises only when requisite additional premium if applicable for such endorsement has been realized.

All other Policy Terms, conditions and exclusions shall remain unaltered.

CASUALTY SECTIONS
Section 1: ACCIDENTAL DEATH
If any Insured Person sustains Injury during the policy period which directly and independently of all other causes result in death within 12 Months from the date of accident, the company agrees to pay to the Insured Person’s Nominee, Beneficiary or legal representative, the Sum Insured specified in the Schedule/Certificate of Insurance.

Section 2: PERMANENT TOTAL DISABLEMENT (PTD)
If any Insured Person sustains Injury during the policy period which directly and independently of all other causes result in any of the disablement stated in the table below and opted for by the Policyholder/Insured Person as indicated in the Policy Schedule/Certificate of Insurance, within twelve months from the date of accident, the company agrees to pay to the Insured Person, the Sum Insured specified in the Schedule to the extent stated in the table below.
The table below states the conditions for disablement and the corresponding percentage of the Policy Term Days (PTD) the company agrees to pay to the Insured Person. In case of injury during the policy period, the company agrees to pay to the Insured Person's Nominee, Beneficiary or Legal Representative the Sum Insured specified in the Schedule to the extent of accident, the company agrees to pay to the Insured Person as indicated in the Schedule/Certificate of Insurance, within twelve months from the date of accident, the company agrees to pay to the Insured Person as indicated in the Schedule/Certificate of Insurance. If any Insured Person sustains Injury during the policy period, the company agrees to pay to the Insured Person's Nominee, Beneficiary or Legal Representative the Sum Insured specified in the Schedule/Certificate of Insurance. If the injury results in permanent total disablement (PTD), the company agrees to pay the Sum Insured specified in the Schedule/Certificate of Insurance. Any endorsement issued with this policy shall modify the scope of coverage to the extent as such endorsement has been realized.

### SECTION 2: PERMANENT TOTAL DISABLEMENT (PTD)

<table>
<thead>
<tr>
<th>Disablement</th>
<th>% of PTD SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of or/and use of 2 limbs (both hands, both feet or one hand and one foot)</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of or/use of one limb and one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Complete and irrecoverable loss of sight of both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech and hearing of both ear</td>
<td>100%</td>
</tr>
<tr>
<td>Incurable Insanity as a result of Injury</td>
<td>100%</td>
</tr>
<tr>
<td>Complete Removal of Lower Jaw</td>
<td>100%</td>
</tr>
<tr>
<td>Total Loss of Mastication</td>
<td>100%</td>
</tr>
<tr>
<td>Total Loss of the central nervous system or the thorax and all abdominal organs</td>
<td>100%</td>
</tr>
<tr>
<td>Quadruplegia (Paralysis) due to Injury</td>
<td>100%</td>
</tr>
</tbody>
</table>

**IN THIS BENEFIT:**
- Loss of Limb means physical separation of a Limb above the wrist or ankle respectively.
- Use of Limb means permanent, irreversible and total loss of functional use of a limb with no reasonable medical hope of improvement.

**SECTION 3: IN-HOSPITAL MEDEX (INPATIENT)**

If any Insured Person sustains Injury during the Policy Period and is hospitalized as an in-patient, then the Company shall reimburse the Insured Person all necessary Usual and Reasonable In-Hospital Medical Expenses, incurred immediately after the Date of Accident, insured under the policy up to the amount specified in the Schedule, subject to the Co-Payment/Deductible/Franchise and Terms and Conditions of this Policy. In-Hospital Medical Expenses shall include Room, ICU & Boarding expenses, Medical Practitioner’s fees, Surgeon’s Fees, Nursing Charges, X-Ray, laboratory & charges, prescribed drugs and medicines, therapeutics, anesthetics (including administration of anesthetics), blood transfusions.

- Incurable Insanity as a result of Injury
- Total Loss of the central nervous system or the thorax and all abdominal organs
- Complete Removal of Lower Jaw
- Total Loss of Mastication
- Loss of Speech and hearing of both ear
- Complete and irrecoverable loss of sight of both eyes

### Disclaimer

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