THE ORIENTAL INSURANCE COMPANY LIMITED

Regd.Office: Oriental House,P.B.No.7037,A-25/27,Asaf Ali Road, New Delhi-110 002

CIN No. U66010DL1947GOI007158

ORIENTAL DENGUE KAVACH
PROSPECTUS

Eligibility:

FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned below:

a) Legally wedded spouse.

b) Dependent Children upto 2 living children (i.e. natural or legally adopted) between the age 91days to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

c) Parents / Parents-in-law (either of them).

SALIENT FEATURES

1. Specialized disease specific benefit cover on detection of Dengue Fever without any sublimit/ co-payment.
2. Sum Insured slabs of INR 10,000 and INR 20,000 only on individual basis.
3. One premium irrespective of age. Period of Insurance is Annual and not short term.
4. No medical checkup required irrespective of age.
5. Extended family Cover under single policy: Self, Spouse, 2 dependent children & Dependent parents/parents-In-Law.
6. Minimum entry age 18 years and maximum entry age 70 years, with lifelong renewability.
7. Only 30 days waiting period from date of inception of policy. No other waiting periods.
8. No Income proof required from proposer for issuance of policy.
9. Discount:

- Online Discount(Fresh/Renewal): 5%, where no intermediary involved
- Family Discount: 2.5% (2 members), 5% (More than 2)

11. Online Claim Settlement by uploading the Doctor's prescription advising the test and the positive Test Result from a Government Approved Diagnostic/Pathological Laboratory in India.

12. Free look/Grace Period facility as per IRDAI Guidelines.

14. For details of coverage please refer to prospectus on our website.

2. COVERAGE/BENEFITS

The Policy covers a lump sum benefit to be paid upto the limit of sum insured mentioned below, if a person is first diagnosed with Dengue Fever during the policy period.

Note: Laboratory criteria for diagnosis include one or more of the following:

1. Demonstration of a fourfold or greater change in reciprocal immunoglobulin G (IgG) or immunoglobulin M (IgM) antibody titers to one or more dengue virus antigens in paired serum samples.
2. Demonstration of dengue virus antigen in autopsy tissue via immunohistochemistry or immunofluorescence or in serum samples via enzyme immunoassay (MAC-ALISA, IgG ELISA, NSI-ELISA and EIA).
3. Detection of viral genomic sequences in autopsy tissue, serum, or cerebral spinal fluid (CSF) samples via reverse-transcriptase polymerase chain reaction (RT-PCR).

3. DEFINITIONS

3.1 CONDITION PRECEDENT shall mean a policy term or condition upon which Our liability under the policy is conditional upon.

3.2 DISCLOSURE TO INFORMATION NORM:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or nondisclosure of any material fact by the policyholder.

3.3 FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned

Sr. No.	INSURED COVERAGE	LIMIT OF BENEFIT
i.	Sum Insured	INR 10,000 and INR 20,000 only on Individual basis

below:

d) Legally wedded spouse.

e) Dependent Children upto 2 living children (i.e. natural or legally adopted) between the age 91days to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

f) Parents / Parents-in-law (either of them).

3.4 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.

3.5 INSURED PERSON means person(s) named as insured person(s) in the schedule of the policy.

3.6 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

3.7 INSURED PERSON means you and each of the others who are covered under this policy as shown in the Schedule.

3.8 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

3.9 MEDICAL PRACTITIONER is 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 the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the Insured or close family members.

3.12 NOTIFICATION OF CLAIM means the process of intimating a claim to insurer only through digital mode on it's portal.

3.13 PERIOD OF INSURANCE means the period for which this Policy is issued, as specified in the Schedule.

3.14 POLICY PERIOD means the period of coverage as mentioned in the schedule.

3.15 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.16 SUM INSURED is the maximum amount of coverage opted for each Insured Person and as shown in the Schedule.

4. GENERAL EXCLUSIONS:

The company shall not be liable to make any payment under this:-

1. For Any Illness, sickness or disease other than Dengue

2. Any claim with respect to Dengue diagnosed prior to Commencement date of this policy or during the waiting period, which is 30 days.

5. CONDITIONS

5.1 BASIS OF INSURANCE:

This Policy is issued based on the truth and accuracy of statements in the proposal. If there is any misrepresentation or non-disclosure of material facts, we will treat the Policy as void ab initio.

5.2 ENTIRE CONTRACT :

This Policy /Prospectus/ Proposal Form and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this Policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the Policy.

5.3 COMMUNICATION :

Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office as shown in the Schedule.

5.4 PAYMENT OF PREMIUM :

There is one single premium charged irrespective of age. The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.5 CLAIMS PROCEDURE:

A. **NOTIFICATION AND REGISTRATION OF CLAIM/CLAIM DOCUMENTS:**

1. In the event of a claim (positive detection/diagnosis of Dengue), the Insured must intimate and register the claim(s) with below mentioned mandatory documents for claim processing in electronic form only to be uploaded on portal facility provided by Insurance Company within 15 days of notification of claim.

2. Duly filled claim form by the Insured Person/claimant (on Portal) along with Copy of Aadhaar card or any other Govt issued photo ID proof as KYC.

3. Lab report with sign and stamp, confirming positive for Dengue fever along with Doctor's prescription (Signed and stamped with MCI Registration Number). The test for Dengue should be conducted in a Government approved diagnostic/pathological laboratory in India.

4. Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant.

Note: All the documents uploaded have to be in original & self attested. If the originals have been submitted to some other company, certified & self attested true copy of the same along with the settlement note should be submitted.

The above stipulations are not intended to prejudice insured's claim, but their compliance is of utmost importance and necessity for insurer to identify and verify all facts and surrounding circumstances relating to a claim and determine its admissibility as per terms & conditions of the policy.

Waiver of the condition for claims intimated and registered beyond 15 days may be considered in extreme cases of hardship where it is proved to the satisfaction of the insurer that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

The Company shall, upon getting the related medical details / relevant information from the Insured Person verify that the person is eligible to claim under the Policy and after satisfying itself will process and pay the lump-sum benefit.

B. **SCRUTINY OF CLAIM DOCUMENTS:**

i. Insurer shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person as the case may be.

ii. If the deficiency in the necessary claim documents is not met or is partially met in 7 working days of the first intimation. Insurer will send a maximum of 3 (three) reminders.

vi. The claim shall be eligible for repudiation if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

C. **CLAIM SETTLEMENT (provision for Penal Interest)**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

5.6 CONTRIBUTION:

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

ii. 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.

1. 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.

2. Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy / policies so chosen.

3. 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.

4. Where an insured 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.

5.8 REPUDIATION/REJECTION OF CLAIM:

a) If Insurer, for any reasons, decides to reject a claim under the policy, insurer shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report ,as the case may be.

b) Where a rejection is communicated by Insurer, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to insurer for reconsideration of the decision.

c) The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, NewDelhi-110002.

d) If the insured is not satisfied with the reply of the Customer Service department under 5.9 (c), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto INR 20 Lacs.

5.9 DISCLAIMER OF CLAIM:

If the Company shall disclaim liability and communicate in writing to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.10 ARBITRATION CLAUSE:

i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties; or
if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.
ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

5.11 FRAUD:

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

5.12 MEDICAL RECORDS:

a) The Insured Person hereby agrees to and authorizes the disclosure, to the Company or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company in connection with any claim made under this Policy or the Company's liability thereunder.

b) The Company agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and will only use it in connection with any claim made under this Policy or the Company's liability thereunder.

c) Any Medical Practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any Treatment/claim preferred under this policy, when and so often as the same may reasonably be required on behalf of the Company.

5.13 CANCELLATION CLAUSE:

A) CANCELLATION BY INSURER:

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

B) CANCELLATION BY INSURED:

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

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to three months	85% of the annual rate
Exceeding three months	Full annual rate

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

6. OTHER TERMS AND CONDITIONS:

6.1 FAMILY SIZE:

Policy offers coverage on individual basis only, so no minimum family size is mandated. All eligible family members as per definition of family 3.3 may be covered under a single policy.

6.2 SUM INSURED:

The Sum Insured options available for the proposer/dependents under this policy are Rs. 10,000/- and Rs.20,000/- on individual basis. The members under the policy may opt for different sum insured.

6.3 ENTRY AGE:

The Proposer for this Insurance should be between the age of 18 years and 70 years with lifelong renewability. Children above the age of 3 months can be covered by the parents / guardians provided they are financially dependent on the parents / guardians.

6.4 MIDTERM INCLUSION:

No Midterm inclusion is allowed. Addition of members is allowed only at the time of renewal.

6.5 ENHANCEMENT OF SUM INSURED:

Insured may seek enhancement of Sum Insured in writing on renewal upto the next immediate applicable slab of Sum Insured, which may be granted subject to the underwriting guidelines and if no claim has been reported by Insured Person(s) seeking enhancement during last immediate preceding policy period.

6.6 FREE LOOK PERIOD:

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover **or**

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

6.7 GRACE PERIOD:

In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing.

6.8 RENEWAL OF POLICY:

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

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

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

6.9 CHANGE OF ADDRESS:

Insured must inform the Company immediately in writing of any change in the address.

6.10 WITHDRAWAL OF POLICY:

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

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

6.11 DISCOUNTS:

a) DISCOUNT ON DIRECT ON-LINE POLICIES:

A discount of 5% on premium is allowed, if the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

b) FAMILY DISCOUNT:

A discount of 2.5% on premium is allowed if 2 members (including the proposer) of a family are covered under single policy & 5% discount in case more than 2 members are insured under single policy.

6.12 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations2016 & Guidelines on Standardization in health insurance, as amended from time to time.

6**.13 GRIEVANCE REDRESSAL:**

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

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in
Fax:

Courier:

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,
New Delhi-110002.

For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

Insurance Ombudsman –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-1[Insurers to take note of the change in domain of the email ids mentioned at Annexure – I, the domain may be changed from gbic.co.in to ecoi.co.in. Insurers are further advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders.]

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

6.14 SINGLE POLICY:

Proposer is not allowed to take multiple Oriental Dengue Benefit Cover policy. This condition shall be applicable to all the Insured persons covered under it.

6.15 Relief under Section 80-D: Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the premium paid by any mode other than cash

6.16 DISCLOSURE TO INFORMATION NORM:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.17 TERRITORIAL JURISDICTION:

All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws.

6.18 IMPORTANT

"IRDAI OR ITS OFFICIALS DO NOT INVOLVE IN ACTIVITIES LIKE SALE OF ANY KIND OF INSURANCE OR FINANCIAL PRODUCTS NOR INVEST PREMIUMS. IRDAI DOES NOT ANNOUNCE ANY BONUS. THOSE RECEIVING

SUCH PHONE CALLS ARE REQUESTED TO LODGE A POLICE COMPLAINT ALONG WITH DETAILS OF PHONE CALLAND NUMBER".

6.19 Prohibition of Rebates: Section 41 of Insurance Act 1938 (Prohibition of rebates): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs rupees.

PREMIUM CHART

INDIVIDUAL PLAN		
S.No.	**Sum Insured (INR)**	**0-70 Years (Age in Completed Years)***
1	10,000	234
2	20,000	468
Premium is INR		
Taxes as applicable shall be extra.		
*Means the age completed as on the date of the policy inception/renewal. So, for a person aged 40 years and 364 days , the completed age would be 40 years and premium would be charged on the age of 40 years, not that of 41 years.		

DISCOUNTS:

1. **Digital Discount**: 5 % Discount, where no intermediary is involved.
2. **Family Discount:**
   - For 2 members: 2.5%
   - For more than 2 members: 5%

ANNEXURE I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Office Details	**Jurisdiction of Office (Union Territory, District)**
AHMEDABAD – Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU – Office of the Insurance Ombudsman, JeevanSoudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078 Tel.: 080 - 26652048 / 26652049	Karnataka

Email: bimalokpal.bengaluru@gbic.co.in	
BHOPAL – Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR – Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009 Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH – Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017 Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigar
CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018 Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI – Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002 Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI - Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004 Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR – Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005 Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in	Rajasthan

ERNAKULAM - 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@gbic.co.in	Kerala, Lakshadweep, Mahe - a part of Pondicherry
KOLKATA – Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072 Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW – Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001 Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, JeevanSeva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054 Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA – Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301 Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA – Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006 Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand
PUNE – Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030 Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in	Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

THE ORIENTAL INSURANCE COMPANY LIMITED

Regd.Office: Oriental House,P.B.No.7037,A-25/27,Asaf Ali Road, New Delhi-110 002

CIN No. U66010DL1947GOI007158

ORIENTAL DENGUE KAVACH

POLICY DOCUMENT

1. WHEREAS the insured named in the Schedule hereto has by a proposal and declaration (which shall be the basis of this Contract and is deemed to be incorporated herein) has applied to **THE ORIENTAL INSURANCE COMPANY LIMITED** (hereinafter called the Company) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the INSURED PERSON (S)) and has paid premium to the Company as consideration for such insurance to be serviced by the Company.

Now this Policy witnesses that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the period of insurance stated in the Schedule any Insured Person(s) shall be diagnosed to be suffering from Dengue Fever (herein after called Dengue) duly supported by a specific positive diagnostic report as defined by Government Authorities from a Government approved Diagnostic/Pathological laboratory in India, we will pay the entire Sum Insured, as specified in the Policy Certificate against this cover, as a lump sum amount.

It is a condition precedent that the detection of positive diagnostic report should be after the initial waiting period of 30 days as defined in the policy wordings and the diagnostic report should be signed and stamped, confirming positive for Dengue fever conducted in a Government approved diagnostic/pathological laboratory in India.

2. COVERAGE/BENEFITS

The Policy covers a lump sum benefit to be paid upto the limit of sum insured mentioned below, If a person is first diagnosed with Dengue Fever during the policy period.

Sr. No.	**INSURED COVERAGE**	**LIMIT OF BENEFIT**
i.	Sum Insured	INR 10,000 and INR 20,000 only on Individual basis

Note: Laboratory criteria for diagnosis include one or more of the following:

1. Demonstration of a fourfold or greater change in reciprocal immunoglobulin G (IgG) or immunoglobulin M (IgM) antibody titers to one or more dengue virus antigens in paired serum samples.

2. Demonstration of dengue virus antigen in autopsy tissue via immunohistochemistry or immunofluorescence or in serum samples via enzyme immunoassay (MAC-ALISA, IgG ELISA, NSI-ELISA and EIA).

3. Detection of viral genomic sequences in autopsy tissue, serum, or cerebral spinal fluid (CSF) samples via reverse-transcriptase polymerase chain reaction (RT-PCR).

3. DEFINITIONS

3.1 CONDITION PRECEDENT shall mean a policy term or condition upon which Our liability under the policy is conditional upon.

3.2 DISCLOSURE TO INFORMATION NORM:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or nondisclosure of any material fact by the policyholder.

3.3 FAMILY consists of the Insured and/ or anyone or more of the family members as mentioned below:

a) Legally wedded spouse.

b) Dependent Children upto 2 living children (i.e. natural or legally adopted) between the age 91days to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughter / daughters are also eligible for coverage under the Policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

c) Parents / Parents-in-law (either of them).

3.4 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.

3.5 INSURED PERSON means person(s) named as insured person(s) in the schedule of the policy.

3.6 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

3.7 INSURED PERSON means you and each of the others who are covered under this policy as shown in the Schedule.

3.8 MEDICAL ADVICE means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

3.9 MEDICAL PRACTITIONER is 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 the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the Insured or close family members.

3.12 NOTIFICATION OF CLAIM means the process of intimating a claim to insurer only through digital mode on it's portal.

3.13 PERIOD OF INSURANCE means the period for which this Policy is issued, as specified in the Schedule.

3.14 POLICY PERIOD means the period of coverage as mentioned in the schedule.

3.15 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.16 SUM INSURED is the maximum amount of coverage opted for each Insured Person and as shown in the Schedule.

4. GENERAL EXCLUSIONS:

The company shall not be liable to make any payment under this:-

1. For Any Illness, sickness or disease other than Dengue

2. Any claim with respect to Dengue diagnosed prior to Commencement date of this policy or during the waiting period, which is 30 days.

5. CONDITIONS

5.1 BASIS OF INSURANCE:

This Policy is issued based on the truth and accuracy of statements in the proposal. If there is any misrepresentation or non-disclosure of material facts, we will treat the Policy as void ab initio.

5.2 ENTIRE CONTRACT :

This Policy /Prospectus/ Proposal Form and declaration given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this Policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the Policy.

5.3 COMMUNICATION :

Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office as shown in the Schedule.

5.4 PAYMENT OF PREMIUM :

There is one single premium charged irrespective of age. The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The payment of premium and the observance and fulfilment of the terms, provisions, conditions and

endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.5 CLAIMS PROCEDURE:

A. **NOTIFICATION AND REGISTRATION OF CLAIM/CLAIM DOCUMENTS:**

1. In the event of a claim (positive detection/diagnosis of Dengue), the Insured must intimate and register the claim(s) with below mentioned mandatory documents for claim processing in electronic form only to be uploaded on portal facility provided by Insurance Company within 15 days of notification of claim.

2. Duly filled claim form by the Insured Person/claimant (on Portal) along with Copy of Aadhaar card or any other Govt issued photo ID proof as KYC.

3. Lab report with sign and stamp, confirming positive diagnosis for Dengue fever along with Doctor's prescription (Signed and stamped with MCI Registration Number),. The test for Dengue should be conducted in a Government approved diagnostic/pathological laboratory in India.

4. Cancelled cheque and NEFT mandate form - duly filled in by the Insured Person/claimant.

Note: All the documents uploaded have to be in original & self attested. If the originals have been submitted to some other company, certified & self attested true copy of the same along with the settlement note should be submitted.

The above stipulations are not intended to prejudice insured's claim, but their compliance is of utmost importance and necessity for insurer to identify and verify all facts and surrounding circumstances relating to a claim and determine its admissibility as per terms & conditions of the policy.

Waiver of the condition for claims intimated and registered beyond 15 days may be considered in extreme cases of hardship where it is proved to the satisfaction of the insurer that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

The Company shall, upon getting the related medical details / relevant information from the Insured Person verify that the person is eligible to claim under the Policy and after satisfying itself will process and pay the lump-sum benefit.

B. **SCRUTINY OF CLAIM DOCUMENTS:**

i. Insurer shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person as the case may be.

ii. If the deficiency in the necessary claim documents is not met or is partially met in 7 working days of the first intimation. Insurer will send a maximum of 3 (three) reminders.

vi. The claim shall be eligible for repudiation if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

C. **CLAIM SETTLEMENT (provision for Penal Interest)**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).

5.6 CONTRIBUTION:

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

ii. 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.

1. 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.

2. Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy / policies so chosen.

3. 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.

4. Where an insured 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.

5.8 REPUDIATION/REJECTION OF CLAIM:

a) If Insurer, for any reasons, decides to reject a claim under the policy, insurer shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report, as the case may be.

b) Where a rejection is communicated by Insurer, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to insurer for reconsideration of the decision.

c) The Insured Person shall have the right to appeal / approach the Customer Service department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, NewDelhi-110002.

d) If the insured is not satisfied with the reply of the Customer Service department under 5.9 (c), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto INR 20 Lacs.

5.9 DISCLAIMER OF CLAIM:

If the Company shall disclaim liability and communicate in writing to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of Law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.10 ARBITRATION CLAUSE:

i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties; or

if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.

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

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

5.11 FRAUD:

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

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

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

5.12 MEDICAL RECORDS:

a) The Insured Person hereby agrees to and authorizes the disclosure, to the Company or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from which the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company in connection with any claim made under this Policy or the Company's liability thereunder.

b) The Company agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and will only use it in connection with any claim made under this Policy or the Company's liability thereunder.

c) Any Medical Practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any Treatment/claim preferred under this policy, when and so often as the same may reasonably be required on behalf of the Company.

5.13 CANCELLATION CLAUSE:

A) CANCELLATION BY INSURER:

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

B) CANCELLATION BY INSURED:

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

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED (RETAINED)
Up to three months	85% of the annual rate
Exceeding three months	Full annual rate

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

6. OTHER TERMS AND CONDITIONS:

6.1 FAMILY SIZE:

Policy offers coverage on individual basis only, so no minimum family size is mandated. All eligible family members as per definition of family 3.3 may be covered under a single policy.

6.2 SUM INSURED:

The Sum Insured options available for the proposer/dependents under this policy are Rs. 10,000/- and Rs.20,000/- on individual basis. The members under the policy may opt for different sum insured.

6.3 ENTRY AGE:

The Proposer for this Insurance should be between the age of 18 years and 70 years with lifelong renewability. Children above the age of 3 months can be covered by the parents / guardians provided they are financially dependent on the parents / guardians.

6.4 MIDTERM INCLUSION: No Midterm inclusion is allowed. Addition of members is allowed only at the time of renewal.

6.5 ENHANCEMENT OF SUM INSURED:

Insured may seek enhancement of Sum Insured in writing on renewal upto the next immediate applicable slab of Sum Insured, which may be granted subject to the underwriting guidelines and if no claim has been reported by Insured Person(s) seeking enhancement during immediate preceding policy period.

6.6 FREE LOOK PERIOD:

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover **or**

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

6.7 GRACE PERIOD:

In the event of delay in renewal of the Policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/Injury contracted during the break period shall not be covered and shall be treated as Pre-existing.

6.8 RENEWAL OF POLICY:

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

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

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

6.9 CHANGE OF ADDRESS:

Insured must inform the Company immediately in writing of any change in the address.

6.10 WITHDRAWAL OF POLICY:

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

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

6.11 DISCOUNTS:

a) DISCOUNT ON DIRECT ON-LINE POLICIES:

A discount of 5% on premium is allowed, when the Policy is purchased on-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.

b) FAMILY DISCOUNT:

A discount of 2.5% on premium is allowed if 2 members (including the proposer) of a family are covered under single policy & 5% discount in case more than 2 members are insured under single policy.

6.12 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations2016 & Guidelines on Standardization in health insurance, as amended from time to time.

6**.13 GRIEVANCE REDRESSAL:**

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

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in
Fax:
Courier:
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,
New Delhi-110002.
For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

Insurance Ombudsman –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-1[Insurers to take note of the change in domain of the email ids mentioned at Annexure – I the domain may be changed from gbic.co.in to ecoi.co.in. Insurers are further advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders.]

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

6.14 SINGLE POLICY:

Proposer is not allowed to take multiple Oriental Dengue Benefit Cover policy. This condition shall be applicable to all the Insured persons covered under it.

6.15 Relief under Section 80-D: Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the premium paid by any mode other than cash.

6.16 DISCLOSURE TO INFORMATION NORM:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.17 TERRITORIAL JURISDICTION:

All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws.

6.18 IMPORTANT

"IRDAI OR ITS OFFICIALS DO NOT INVOLVE IN ACTIVITIES LIKE SALE OF ANY KIND OF INSURANCE OR FINANCIAL PRODUCTS NOR INVEST

PREMIUMS. IRDAI DOES NOT ANNOUNCE ANY BONUS. THOSE RECEIVING SUCH PHONE CALLS ARE REQUESTED TO LODGE A POLICE COMPLAINT ALONG WITH DETAILS OF PHONE CALLAND NUMBER".

6.19 Prohibition of Rebates: Section 41 of Insurance Act 1938 (Prohibition of rebates): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer: Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakhs rupees.

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ANNEXURE I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Office Details	**Jurisdiction of Office (Union Territory, District)**
AHMEDABAD – Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU – Office of the Insurance Ombudsman, JeevanSoudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078 Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in	Karnataka
BHOPAL – Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR – Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009 Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH – Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh –	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigar

160 017 Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in	
CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018 Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI – Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002 Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI - Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004 Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR – Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005 Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM - 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@gbic.co.in	Kerala, Lakshadweep, Mahe - a part of Pondicherry
KOLKATA – Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072 Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW –	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur,

Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001 Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in	Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, JeevanSeva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054 Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA – Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301 Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA – Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006 Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand
PUNE – Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030 Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in	Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region