सर्व हरियाणा ग्रामीण बैंक
Sarva Haryana Gramin Bank
(भारत सरकार का उपक्रम) (Govt. of India Undertaking)
प्रायोजक : पंजाब नैशनल बैंक Sponsored by: Punjab National Bank

SHGB HOUSE, PLOT No. 1, SEC-3, HEAD OFFICE, ROHTAK
(HUMAN RESOURCES DEVELOPMENT DIVISION)

Sarva Haryana Gramin Bank
H.O. SHGB House, Plot No.1, Sector-3, Rohtak- 124001 (Haryana)

Notice inviting Tenders

For Group Mediclaim Insurance Policy for Employees

Sarva Haryana Gramin Bank invites tenders from established Insurers for Group Mediclaim Insurance Policy for employees of the bank. Insurance Companies registered with IRDA having atleast **05** years' experience in the field of General Insurance/ Health Insurance in India may upload their bids at GeM portal addressed to the General Manager, Human Resource Development Division, Sarva Haryana Gramin Bank, Head Office, SHGB House Plot No. 1 Sector -3 Rohtak-124001 as per the schedule. All the interested insurance companies are advised to go through the detailed tender guidelines before submitting their proposals **through Gem portal only**. The Bank reserves its right to accept or reject any or all the tenders without citing any reasons whatsoever, at any stage.

- **The complete bidding process will be executed through GEM**
- **Portal only.**
- **Addendum/Corrigendum, if any, to this tender will be published on Bank's website only.**
- **No Physical Document will be required to submit to Bank.**

Last date and Time of submission of bids: 09/04/2024 up to 5:00 PM

BID DOCUMENT

Policy: Group Mediclaim Insurance Policy for SARVA HARYANA GRAMIN BANK (SHGB) IN-Serving Employees.

Broker-Anand Rathi Insurance Brokers Limited (ARIBL)

1. INTRODUCTION

Insured: Sarva Haryana Gramin Bank

Sarva Haryana Gramin Bank invites bid for Group Mediclaim Insurance Policy from General insurance companies/ Standalone Health Insurance Companies registered with IRDA through Anand Rathi Insurance Brokers Limited, who has been appointed by Bank. The interested insurance companies may submit their bid to the GEM Portal as per the Bid instructions.

- The complete bidding process will be executed through GEM Portal only.
- Addendum/Corrigendum, if any, to this tender will be published on Bank's website only
- No Physical Document will be required to submit to the Bank.

2. DISCLAIMER

The information contained in this Bid Document is provided to the Bidder(s) on the terms and conditions set out in this BID document. The BID document contains statements and information that is believed to be true and reliable as on date of issue of BID DOCUMENT but does not purport to provide all of the information that may be necessary or desirable to enable an intending contracting party to determine their participation or to enter into a contract or arrangement with Bank in relation to the provision of services.

The BID DOCUMENT is not a recommendation, offer or invitation to enter into a contract, agreement or any other arrangement in respect of the services. The provision of the services is subject to observance of duly notified selection process and appropriate documentation between the Bank and any successful Bidder as identified by the Bank, after completion of the selection process as detailed in this document. No contractual obligation whatsoever shall arise from the BID DOCUMENT process unless and until a formal contract is signed and executed by duly authorized officers of Sarva Haryana Gramin Bank with the Bidder. The purpose of this BID DOCUMENT is to provide the Bidder(s) with information to assist the formulation of their proposals.

This BID DOCUMENT does not claim to contain all the information each Bidder may require. Each Bidder should conduct their own investigations and analysis and should check the accuracy, reliability and completeness of the information in this BID DOCUMENT and where necessary obtain independent advice. Sarva Haryana Gramin Bank makes no representation or warranty and shall incur no liability under any law, statute, rules or regulations as to the accuracy, reliability or completeness of this BID DOCUMENT. Sarva Haryana Gramin Bank may in its absolute discretion, but without being under any obligation to do so, update, amend or supplement the information in this BID DOCUMENT.

3. BANK PROFILE:

Sarva Haryana Gramin Bank came into existence after amalgamation of 2 RRBs namelyHaryana Gramin Bank, Head Office, Rohtak (Sponsored by Punjab National Bank) & Gurgaon Gramin Bank, Head Office, Gurgaon (Sponsored by Syndicate Bank) vide Notification dated 29.11.2013. At present, the Head Office of the Bank is at Rohtak. Sarva Haryana Gramin Bank operates in all **22** Districts of Haryana State. Sarva Haryana Gramin Bank is having **682** Branches all over Haryana.

The detail of administrative offices and branches as under:

Sarva Haryana Gramin Bank (As on 20.03.2024)	
Head office	1
No. of Regional Offices	10
No. of Branch Offices	682
No. of Currency Chest	2
No. of Back Office	1
No. of Employees	**3334**

The bid Documents contains two Parts:

Part I- Terms and conditions related to Bids Submission

Part II- Terms and conditions related to Coverages for the renewal of Insurance policy

Part I

Terms and conditions related to Bids Submission:

Objectives of the BID DOCUMENT

Bank intends to renew the Group Mediclaim Insurance Policy of Sarva Haryana Gramin Bank for sum insured values along with list of coverage as stated in this document for the policy period of one year with effect from **1st May 2024 to 30th April 2025**.

Sarva Haryana Gramin Bank intends to issue this bid document, hereinafter called BID DOCUMENT, to eligible Insurance Companies in India, hereafter called as "Bidders", to participate in the competitive bidding through Gem Portal.

All offers of the bidders shall be unconditional and once accepted whether with or without modifications by the Bank shall be binding between the Bank and such Bidder.

Bank will not accept any deviations from the terms and conditions specified in this BID DOCUMENT. Deviations could result in disqualification of the offer made by the bidder at the discretion of the Bank.

4 DEVIATIONS FROM BID DOCUMENT SPECIFICATIONS:

It is mandatory that the bidder should confirm to BID DOCUMENT's specifications in full and provide a declaration for the same. Bidders are advised not to quote any alternative coverage options/limits/cover design options.

Any deviation will make the bidder liable to be disqualified. The bidder will be bound to comply with the provisions set forth in the BID DOCUMENT

In case of any additional clarification, feel free to connect the following persons

From Sarva Haryana Gramin Bank		
Ms. Sonia	hohrdshgb@shgbank.co.in	9996176400
Mr. Pawan	hohrdshgb@shgbank.co.in	8571806047
From M/s Anand Rathi Insurance Brokers Ltd		
Ms. Shaifali	shaifaligoyal@rathi.com	8800283339
Mr. Viplav	viplavdas@rathi.com	8130021531
Mr. Devendra Singh	devendrasingh1@rathi.com	9713660245

SHGB assumes no liability or liability for any cost the bidder may incur in responding to this BID DOCUMENT including travel costs, attending meeting etc.

Note: Any bid received after the last date of the receipt of bids prescribed in GEM Portal, will not be accepted by the Portal. No bid will be modified after submission of bids. No bidder shall be allowed to withdraw the bid.

5 BIDDERS ELIGIBILITY CRITERIA:

Only those bidders fulfilling these criteria should respond to the tender:-

1. Insurance company should be registered with IRDA with at least **05** years of experience in the field of General Insurance/Standalone Health Insurance in India and its registration/license should be valid as on the date of bidding. Insurer to submit a valid copy of IRDA license.
2. Insurance company should have a **gross written premium of minimum Rs 1,000 Crores** in last financial year 2022-23 from the Indian operations. Kindly attach the audited balance sheet.
3. The bidder should have experience of managing **ONE** Group Mediclaim Insurance policy for at least one Public Sector Organization (PSUs) for a group size of at least **5000** lives covered in the last financial year i.e.2022-23.

Note: Bidder should submit proof in support of above-mentioned criteria while submitting the proposal, the same is to be submitted as of Technical Bid document as per Annexure. Bidders who do not fulfill the above criteria or who fail to submit proof will be rejected ab-initio.

Deviations from BID DOCUMENT specifications:

It is mandatory that the bidder should confirm to the BID DOCUMENT specifications in full and provide a declaration to the same. Bidders are advised not to quote any alternative coverage options / limits/ cover design options.

Any deviation from the BID DOCUMENT condition would disqualify the bidder.

Proposal Process Management:

1. Sarva Haryana Gramin Bank reserves the right to accept or reject any or all proposals, to revise the BID DOCUMENT, to request one or more re- submissions from all bidders or clarifications from one or more bidders, or to cancel the process in part or whole. All claims for functional/technical delivery made by the bidders in their responses to the BID DOCUMENT shall be assumed as deliverable within the quoted financials.

2. The Bidder shall bear all costs associated with the preparation and submission of its bid, and the Bank will, in no case be responsible or liable for any costs for submission of bids.

Language of Bid

The language of the bid response and any communication with the Bank must be in **English** only. Supporting documents provided with the BID DOCUMENT can be in another language so long as it is accompanied by an attested translation in English, in which case, for purpose of evaluation of the bids, the English translation will govern.

6 BIDDING SUBMISSION INSTRUCTION:

The bidders have to submit bids online on GEM Portal with in prescribed timeline. The complete bid documents need to be uploaded by the bidder duly signed and stamped in the portal.

1) Technical Bid

1. The Technical Bid must be submitted as per provided templates attached as Annexures in this Bid document.
2. The Technical Bid - Annexure A, Annexure B, Annexure C, Annexure D and Annexure E should be completed in all aspects and contain all required information asked for in these documents. It should not contain any price information.
3. The following documents are to be submitted to the bank duly signed & stamped by authorized signatory by the bidders.

Sr. No	Particulars	Details
1	Integrity Pact (IP)- On Rs.100 Non-judicial stamp paper with witness	Annexure A
2	Eligibility Criteria- Copy of supporting documents to be provided by the bidders	Annexure B
3	Nil deviation declaration letter- On Bidders letterhead	Annexure C
4	Covering Letter- On Bidders letterhead	Annexure D
5	Undertaking by Bidder- On Bidders letterhead	Annexure E
6	Proof of copy of Signing Authority Letter	

a) Integrity Pact (IP) as provided in Annexure A. It should be duly signed by authorized signatories of the firm, which is an integral part of tender/bid documents, failing which the tenderer/bidder will stand disqualified from the tendering process and the bid of the bidder would be summarily rejected. Integrity Pact will be submitted by the bidder on Rs.100 Non-Judicial Stamp Paper with witnesses and no deviation will be allowed in the format.
b) Eligibility criteria as provided for in Annexure B, along with supporting documents attached.
c) Nil Deviation letter to be submitted as provided in Annexure C without deviation in any terms and condition to this Bid document. Deviated terms if any will be discarded as ab- initio.

d) Annexure C, D and E are to be submitted in portal as per format prescribed by the Bank and should bear the bidders' seal and the name, designation and signature of the Authorized Signatory of the bidder.

e) The bidder's one of the offices must be in **Delhi/NCR/Rohtak.**

f) The bidder should ensure that all the annexures are submitted as prescribed by the Bank. In case it is not in the prescribed format, it is liable to be rejected.

g) The Bank further reserves the right to reject any or all offers based on its own evaluation of the offers received, or based on stability, capabilities, track records, reputation among users and other similar features of a bidder.

h) The Bank reserves the right to modify any terms, conditions or specifications for submission of bids and to obtain revised Bids from the bidders due to such changes, if any at any time prior to completion of evaluation of technical bids from the participating bidders.

i) The bidders have to submit bids online on GEM Portal with in prescribed timeline. The complete bid documents need to be uploaded by the bidder duly signed and stamped in the portal.

No Physical presence for technical and commercial bid submission is allowed.

- The bidder should sign the bid on all the pages by a duly authorized person. The signatory should give a declaration and thorough authenticated documentary evidence to establish that he/she is empowered to sign the tender documents. The bidding document signed by the authorized signatories shall be binding on the bidder.
- The bid should contain no interlineations, erasures, or over writings except as necessary to correct errors made by the bidder. In such a case, the person signing the bid should authenticate such corrections.
- The bidder is expected to examine all instructions, forms, terms, conditions, and technical specifications in the bid documents. Failure to furnish all information required by the Bid Document or submission of a bid not substantially responsive to the bidding documents in every respect will be at the bidder's risk and may result in the rejection of the bid.
- No rows/ columns of the tender should be left blank. Offers with insufficient information and offers, which do not strictly comply with the stipulations given above are liable for rejection

Note- Financial price bid break up sheet is not to be submitted along with the technical bid documents.

Other Terms:

a. The proposal must clearly mention that it is non-cancellable for any reason other than non-payment of premium.
b. Hard copy of integrity pact (duly signed & stamped) on Rs.100 non-judicial stamp paper to be provided by the L1 bidder at the time of awarding the policy.

IEMs of Bank are :-

a) Sh. Satish Chander; E-mail ID: satishchander.adg@gmail.com
b) Sh. Jagdeep Kumar Ghai; E-mail ID: jkghai@gmail.com

2) Financial Bid:

a. The Financial bid must be uploaded in tab given in GEM Portal.
b. Premium quoted should be as per instruction on GEM portal for with or without GST showing on tab.
c. Opening of the financial bids will be subject to the Bidders getting shortlisted on the basis of technical evaluation.
d. The rates quoted must be the final and shall be considered firm regardless of actual claims experience as on the policy effective date.

e. **Gross Total Premium (with GST**) quoted on the Gem-Portal financial tab will be considered as final for selection of **L1 bidder**.

7 IMPORTANT TERMS:

1. The bid/terms offered would not have any "premium/claims Review "clause.
2. The proposal must clearly mention that it is non-cancellable for any reason other than non-payment of premium.

8. Bidding Evaluation Process:

a. It may kindly be noted that a financial bidding process will be followed for the final selection of the Insurance Company for the renewal of Group Mediclaim Insurance Policy of Bank In-Serving Employees.

SHGB reserves the right to:

- Reject any or all responses received in response to the BID DOCUMENT without assigning any reason.
- Cancel the BID DOCUMENT / tender at any stage, without assigning any reason.
- Waive or change formalities, irregularities or inconsistencies in this proposal. Such change/waiver would be duly notified to all insurance companies before the scheduled closure of the bid date.
- Extend the time of submission of all proposals and such an extension would be duly communicated to all the companies.
- Share the information/clarification provided in response to the BID DOCUMENT by any bidder, with all other bidders (s) /others, in the same form as clarified to the bidder raising the query.

9. BID DOCUMENT CONDITIONS:

a. **Bidder warranties**- By submitting a response, the bidder represents and warrants to SHGB/ARIBL that, as at the date of submission:
   I. The bidder has fully disclosed to SHGB/ARIBL in its response all information that could reasonably be regarded as affecting in any way SHGB's/ARIBL evaluation of response.
   II. All information contained in the bidder's response is true, accurate and complete and not misleading in any way.
   III. No litigation, arbitration or administrative proceeding is presently taking place, pending or to the knowledge of bidder threatened against or otherwise involving the bidder which could have an adverse effect on its business, assets or financial condition or upon SHGB's or ARIBL reputation if the response is successful .
   IV. The bidder will immediately notify SHGB and Anand Rathi Insurance Brokers Limited of the occurrence of any event, fact or circumstance which may cause a material adverse effect on the bidder's business, assets or financial condition or SHGB's/ARIBL reputation or render the bidder unable to perform its obligations under the policy contract/ service level agreement, if any or have a material adverse effect on the evaluation of the responses by SHGB/ARIBL; and
   V. The bidder has not and will not seek to influence any decision of SHGB during the evaluation process or engage in any uncompetitive behavior or other practice which may deny legitimate business opportunities to other bidders.

b. **Confidentiality**- Bidder must keep confidential any information received from or about SHGB as a result of or in connection with the submission of the response. All information contained in the response or in subsequent communication shall be deemed confidential and may be used only in connection with the preparation of bidder's response. Unless

expressly agreed in writing, prior to submission, responses are not confidential and may be used by SHGB in whole or part. SHGB however, will not disclose the information provided by bidder in a response other than to its affiliates or to its professional advisors, unless required otherwise by any provisions of law.

c. The BID DOCUMENT is not an offer to contract, nor should it be construed as such. It is a definition of specific SHGB requirements and an invitation to recipients to submit a responsive proposal addressing such requirements. SHGB reserves the right to make no selection and enter into no agreement as a result of this BID DOCUMENT

d. It should be understood that your response to this BID DOCUMENT constitutes an offer to do business on the terms stated in your response and that, should a contract be awarded to you. SHGB may, at its option, incorporate all or any part of your response to this BID DOCUMENT in the contract. SHGB reserves the right to accept your offer without further discussion and without any additional opportunity for you to amend, suspend or revise your offer.

e. **Financial documents**: SHGB may request additional financial/ business information from the bidder at its discretion.

f. **Selection Criteria**: The selection criteria, enquiries, questions or information put forth in the response are meant to be provided on the aforesaid and established through the details submitted by the bidder in the bid.

g. **Termination or suspension of the evaluation process-** SHGB reserves the right to suspend or terminate the bid through Anand Rathi Insurance Brokers Limited during evaluation process at any time in its absolute discretion and without liability to the bidder or any third party. Bidders will be notified if any suspension or termination occurs but SHGB and ARIBL is not obliged to provide any reason.

h. **Other rights**- Without limiting its rights under any other clause of the evaluation process or at law, and without liability to the bidder or any third party, SHGB may at any stage of the evaluation process:
    i. Require additional information from a bidder
    ii. Change the structure and timing for evaluation process
    iii. Vary or extend the timeline for evaluation process
    iv. Negotiate with L1 bidder

i. **Responsibility for Costs**- Bidder is responsible for all costs, expenses or liabilities incurred by him or on his behalf in relation to the evaluation process (including in relation to providing SHGB with the response, the revised response or any additional information)

j. **SHGB's right to vary**- SHGB, through Anand Rathi Insurance Brokers Limited reserves the right to vary any aspect of this valuation process, without liability of the bidder. Where SHGB and ARIBL vary any aspect of this evaluation process or the agreement, SHGB/ ARIBL shall notify the bidder of any variation as far as possible.

k. **Incorporation of responses into agreement** - The successful bidder as concluded by SHGB and ARIBL shall sign a service level agreement. SHGB and ARIBL will incorporate the successful response of the successful bidder into the final service level agreement. ARIBL may require a successful bidder to submit, before negotiation of the service level agreement, details of issues which may affect the ability to act as a bidder.

l. **Precedence of documents**- If there are any inconsistency between the terms of this BID DOCUMENT and any of its appendices, schedules or attachments then, unless the contrary is explicitly stated in this BID DOCUMENT, the terms of the BID DOCUMENT will prevail to the extent of any inconsistency.

m. **Governing laws & dispute resolution-** The BID DOCUMENT and selection process shall be governed by and construed in accordance with the laws of India. Any dispute arising out of the BID DOCUMENT process shall be referred to arbitration under the Arbitration & Conciliation Act, 1996. The arbitral tribunal shall consist of one arbitrator- to be appointed by SHGB. The venue of arbitration shall be **Rohtak**.

n. The evaluation process as communicated earlier shall continue without any changes.

o. In the event that you elect not to respond to this BID DOCUMENT, then the restrictions shall continue to apply to the use or disclosure of this information. Additionally, bidders must immediately return this document and certify in writing to SHGB/ARIBL, that all copies have been returned to SHGB / ARIBL or destroyed.

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Annexure A

(INTEGRITY PACT)

Date:

To,

The General Manager
HRDD
Sarva Haryana Gramin Bank
Head Office, Rohtak

Sub: Submission of Tender for the Group Mediclaim Insurance Policy of Bank In –Serving Employees

Dear Sir,

I/We acknowledge that SHGB is committed to follow the principles thereof as enumerated in the Integrity Agreement enclosed with the tender/bid document.

I/We agree that the Notice Inviting Tender (NIT) is an invitation to offer made on the condition that I/We will sign the enclosed integrity Agreement, which is an integral part of tender documents, failing which I/We will stand disqualified from the tendering process. I/We acknowledge that THE MAKING OF THE BID SHALL BE REGARDED AS AN UNCONDITIONAL AND ABSOLUTE ACCEPTANCE of this condition of the NIT.

I/We confirm acceptance and compliance with the Integrity Agreement in letter and spirit and further agree that execution of the said Integrity Agreement shall be separate and distinct from the main contract, which will come into existence when tender/bid is finally accepted by SHGB.

I/We acknowledge and accept the duration of the Integrity Agreement, which shall be in line with Part I of Annexure A of the enclosed Integrity Agreement.

I/We acknowledge that in the event of my/our failure to sign and accept the Integrity Agreement, while submitting the tender/bid, SHGB shall have unqualified, absolute and unfettered right to disqualify the tenderer/bidder and reject the tender/bid is accordance with terms and conditions of the tender/bid.

Yours faithfully,

(Duly authorized signatory of the Bidder)

Integrity Pact

Rs.100 non-judicial stamp paper

Integrity Pact Format Pre Contract Integrity Pact

This pre-bid contract Agreement (herein after called the Integrity Pact) is made on_____ day of the_____month 20_____between Sarva Haryana Gramin Bank, a Regional Rural Bank body constituted after amalgamation through Gazette Notification dated 29.11.2013 issued bythe Government of India (Banking Division), in exercise of powers conferred under RRB Act, 1976 sponsored by Punjab National Bank carrying on Banking Business and having its Head Office at Plot No. 1. Sector 3, Rohtak. 124001, (Haryana) hereinafter referred to as "The Principal" which expression shall mean and include unless the context otherwise requires, its successors in office and assigns of the First Part.

And

M/s._____having its registered office at _____Hereinafter referred to as "The Bidder/Contractor", expression shall mean and include unless the context otherwise requires, successors and permitted assigns ofthe Second part.

Preamble

The Principal intends to award, under laid down organizational procedures, contract/s for… ThePrincipal values full compliance
With all relevant laws of the land, rules, regulations, economic use of resources and of fairness/transparency in its relations with its Bidder(s) and/or Contractor(s).

In order to achieve these goals, the Principal will appoint Independent External Monitors (IEMs) who will monitor the tender process and the execution of the contract for compliance with the principlesmentioned above.

Section 1- Commitments of the Principal

(1) The Principal commits itself to take all measures necessary to prevent corruption andto observethe following principles:-

a. No employee of the Principal, personally or through family members, will in connection with the tender for, or the execution of a contract, demand, take a promise for or accept, for self or third person, any material or immaterial benefit which the person is not legally entitled to.

b. The Principal will, during the tender process treat all Bidder(s) with equity and reason. The Principal will in particular, before and during the tender process, provide to all Bidder(s) the same information and will not provide to any Bidder(s) confidential/additional information through which theBidder(s) could obtain an advantage in relation to the tender process or the contract execution.

c. The Principal will exclude from the process all known prejudiced person.

(2) If the Principal obtains information on the conduct of any of its employees which is a criminal offence under the IPC/PC Act, or if there be a substantive suspicion in this regard, the Principal willinform the Chief Vigilance Officer and in addition can initiate disciplinary actions.

Section 2- Commitments of the Bidder(s) / Contractor(s)

(1) The Bidder(s)/Contractor(s) commit themselves to take all measures necessary to prevent corruption during any stage of bid process/contract. The Bidder(s)/Contractor(s) commit themselves to observe the following principles during participation in the tender process and during the contract execution.

a. The Bidder(s)/Contractor(s) will not, directly or through any other person or firm, offer promise orgive to any of the Principal's employees involved in the tender process or the execution of the contract or to any third person any material or the other benefit which he/she is not legally entitled to, in order to obtain in exchange any advantage of any kind whatsoever during the tender process or during the execution of the contract.

b. The Bidder(s)/Contractor(s) will not enter with other Bidders into any undisclosed agreement or understanding, whether formal or informal. This applies in particular to prices, specifications, certifications, subsidiary contracts, submission or non-submission of bids or any other actions to restrict competitiveness or to introduce cartelization in the bidding process.

c. The Bidder(s)/ Contractor(s) will not commit any offence under the relevant IPC/PC Act; further the Bidder(s)/Contractor(s) will not use improperly, for purposes of competition or personal gain, orpass on to others, any information or document provided by the Principal as part of the business relationship, regarding plans., technical proposal and business details, including information contained or transmitted electronically.

d. The Bidder(s)/Contractor(s) of foreign origin shall disclose the name and address of the Agents/representatives in India, if any, similarly the Bidder(s)/Contractor(s) of Indian Nationality shall furnish the name and address of the foreign principals, if any. Further details as mentioned inthe "Guidelines on Indian Agents of Foreign Suppliers" shall be disclosed by the Bidder(s)/Contractor(s). Further, as mentioned in the Guidelines all the payments made to the Indianagent/representative have to be in Indian Rupees only.

e. The Bidder(s)/Contractor(s) will, when presenting their bid, disclose any and all payments made, is committed to or intends to make to agents, brokers or any other intermediaries in connection withthe award of the contract.

f. Bidder(s)/Contractor(s) who have signed the Integrity Pact shall not approach the Courts while representing the matter to IEMs and shall wait for their decision in the matter.

(2). The Bidder(s)/Contractor(s) will not instigate third persons to commit offences outlined above or be an accessory to such offences.

Section-3 Disqualification from tender process and exclusion from future contracts.

If the Bidder(s)/Contractor(s) before award or during execution has committed a transgression through a violation of Section 2, above or in any other form such as to put their reliability or credibility in question, the Principal is entitled to disqualify the Bidder(s)/Contractor(s) from the tender process or take action as per the procedure mentioned in the "Guidelines on banning of business dealings".

Section 4- Compensation for Damages

(1). If the Principal has disqualified the Bidder(s) from the tender process prior to the award according to Section 3, the Principal is entitled to demand and recover the damages equivalentto earnest Money Deposit/Bid Security.

(2). If the Principal has terminated the contract according to Section 3, or the Principal is entitled to terminate the contract according to Section 3, the Principal shall be entitled to demand and recoverfrom the Contractor liquidated damages of the contract value or the amount equivalent to Performance Bank Guarantee.

Section 5- Previous transgression

(1) The Bidder declares that no previous transgression occurred in the last three years immediate before signing of this integrity pact with any other Company in any country conforming to the anti- corruption approach or with any Public Sector Enterprises or central/state government department in India that could justify his exclusion from the tender process.

(2). If the Bidder makes incorrect statement on this subject, he can be disqualified from the tender process or action can be taken as per the procedure mentioned in" Guidelines on Banning of business dealing".

Section 6- Equal treatment of all Bidders/Contractors/Subcontractors

(1) In case of sub-contracting, the Principal contractor shall take the responsibility of the adoptionof IP by the sub-contractor. It is to be ensured that all sub-contractors also sign the IP.

(2) The Principal will enter into agreements with identical conditions as this one with all Bidders andContractors.

(3) The Principal will disqualify from the tender process all the Bidders who do not sign this Pact orviolate its provisions.

Section 7- Criminal charges against violating Bidder(s)/ Contractor(s)/Subcontractor(s)

If the Principal obtains knowledge of conduct of a Bidder, Contractor or Sub contractor, or of an employee or a representative or an associate of a Bidder, Contractor or Subcontractor which constitutes corruption, or if the Principal has substantive suspicion in this regard, the Principal will inform the same to the Chief Vigilance Officer.

Section 8- Independent External Monitor

(1) The Principal appoints competent and credible Independent External Monitor for this Pact after approval by Central Vigilance Commission. The task of the Monitor is to review independently and objectively, whether and to what extent the parties comply with the obligations under the agreement.

(2) The Monitor is not subject to instructions by the representatives of the parties and performs his/her functions neutrally and independently. The Monitor would be provided access to all documents/records pertaining to the contract for which a complaint or issue is raised before them, as and when warranted. However, the documents/ records/information having National Security implications and those documents which have been classified as Secret/Top Secret are not to be disclosed. It will be obligatory for him/her to treat the information and documents of the Bidders/Contractors as confidential. He/she reports to the Chairman, Sarva Haryana Gramin Bank.

(3) The Bidder(s)/Contractor(s) accepts that the Monitor has the right to access without restriction to all project documentation of the Principal including that provided by the Bidder(s)/ Contractor(s).The Bidder(s)/Contractor(s) will also grant the Monitor, upon his/her request and demonstration of a valid interest, unrestricted and unconditional access to their project documentation. The same is applicable to Sub-contractor.

(4) The Monitor is under contractual obligation to treat the information and documents of the Bidder(s)/Contractor(s)/Subcontractor(s) with confidentiality. The Monitor has also signed declarations on "Non-Disclosure of Confidential Information" and of "Absence of Conflict of Interest". In case of any conflict of interest arising at a later date, the IEM shall in form MD & CEO, Punjab National Bank and recues himself/herself from that case.

(5) The Principal will provide to the Monitor sufficient information about all meetings among the parties related to the Project provided such meetings could have an impact on the contractual relations between the Principal and Contractor. The parties offer to the Monitor the option to participate in such meetings.

(6) As soon as the Monitor notices, or believes to notice, a violation of this agreement, he/she will so inform the Management of the Principal and request the Management to discontinue or take corrective action, or to take other relevant action. The monitor can in this regard submit non-bindingrecommendations. Beyond this, the Monitor has no right to demand from the parties that they act ina specific manner, refrain from action or tolerate action.

(7) The Monitor will submit a written report to the Chairman, Sarva Haryana Gramin Bank within 8 to10 weeks from the date of reference or intimation to him by the Principal and, should the occasion arise, submit proposals for correcting problematic situations.

(8) If the Monitor has reported to the Chairman, Sarva Haryana Gramin Bank, a substantiated suspicion of an offence under relevant IPC/PC Act, and the Chairman, Sarva Haryana Gramin Bankhas not, within the reasonable time taken visible action to proceed against such offence or reportedit to the Chief Vigilance Officer, the Monitor may also transmit this information directly to the CentralVigilance Commissioner.

(9) The word 'Monitor' would include both singular and plural.

Section 09- Pact Duration

This Pact begins when both parties have legally signed it. It expires for the Contractor 12months after the last payment under the contract, and for all other Bidders 6 months after the contract has been awarded. Any violation of the same would entail disqualification of the bidders and exclusion future business dealings.

If any claim is made/lodged during this time, the same shall be binding and continue to be valid despite the lapse of this pact as specified above, unless it is discharged/ determined by Chairman,Sarva Haryana Gramin Bank.

Section 10- Other provisions

(1) This agreement is subject to Indian Law. Place of performance and jurisdiction is the" Place of award of work". .

(2) The actions stipulated in this Integrity Pact are without prejudice to any other legal action that may follow in accordance with the provisions of to the extant law in force relating to any civil or criminal proceedings.

(3) Changes and supplements as well as termination notices need to be made in writing. Side agreements have not been made.

(4) If the Contractor is a partnership or a consortium, this agreement must be signed by all partnersor consortium members.

(5) Should one or several provisions of this agreement turn out to be invalid, the remainder of this agreement remains valid. In this case, the parties will strive to come to an agreement to their originalintentions.

(6) Issues like warranty/Guarantee etc. shall be outside the purview of IEMs.

(7) In the event of any contradiction between the Integrity Pact and its Annexure, the Clause in theIntegrity Pact will prevail.

(For & On behalf of the Principal) Bidder/Contractor)(Office Seal)	(For & On behalf of (Office Seal)

Place…….

Date…….

Witness 1:	Witness 2:
(Name & Address)	(Name & Address)

Annexure B

Eligibility Criteria

Eligibility Criteria for Bidder	Supporting Documents Required	Complied (Yes/No)
Insurance company should be registered with IRDA with at least **05** years of experience in the field of General Insurance/Stand Health alone Insurance in India and its registration/license should be valid as on the date of bidding. Insurer to submit a valid copy of IRDA license.	Copy of license issued by IRDA / Copy of Premium payment receipt for the license.	
Insurance company should have a gross written premium of **minimum** Rs. **1,000 Crores** in last financial year 2022-23 from the Indian operations. Kindly attach the audited balance sheet.	Self-Declaration to be provided duly signed & stamped on the bidder letter head along with the supporting document showing the premium figures.	
The bidder should have experience of managing **ONE** Group Mediclaim Insurance policies for at least one Public Sector Organization (PSUs) for a group size of at least **5000 lives** covered in the last financial year i.e.2022-23	Declaration along with supporting document needs to be provided	

Authorized Signatory

(Name, Designation and Seal of the Company)

Date:

Note: All supporting documents in regards to above mentioned eligibility criteria need to be uploaded in the portal duly signed and stamped.

Annexure C

Nil Deviation Declaration

To,

The General Manager
HRDD
Sarva Haryana Gramin Bank
Head Office, Rohtak

Dear Sir,

Sub: RESPONSE TO BID DOCUMENT IN CONNECTION WITH GROUP MEDICLAIM INSURANCE POLICY OF THE BANK

Declaration	Yes/No
We confirm that we offer our technical bid to the Bank with NIL deviations with all the terms as mentioned in the BID DOCUMENT	

If the reply to the above declaration is NO, please mention the deviations

1. _____

2. _____

Enclosure

1.	Copy of duly signed and stamped Bid Document	YES / NO

Yours faithfully

Authorized signatory
(Name, Designation and Seal of the Company)

Annexure D

Covering Letter

(to the Bank on the bidder's letterhead)

To,

The General Manager
HRDD
Sarva Haryana Gramin Bank
Head Office, Rohtak

Dear Sir,

Sub: SUBMISSION OF BID IN REGARD TO BID DOCUMENT GROUP MEDICLAIM INSURANCE POLICY OF THE BANK

With reference to the captioned BID DOCUMENT, having examined and understood the instructions, terms and conditions, we hereby enclose our Bid for the Group Mediclaim insurance policy for the Bank In- Serving Employees. We confirm that the offer is in conformity with the terms and conditions as mentioned in your above referred BID DOCUMENT.

We further confirm that the information furnished in the proposal, annexure formats etc. is correct. Bank may make at its own discretion inquire for verification of submitted information and we understand that the Bank has the right to disqualify and reject the proposal, if any of the information furnished in the proposal is not corrector false without assigning any reasons thereof.

We have appointed following Official to deal with the Bank in regard to the captioned insurance policy.

Name of the Official:

Designation:

Mobile No:

E-Mail ID:

Yours faithfully,

Authorized Signatory

(Name, Designation and Seal of the Company)

Date

Annexure E

Undertaking by Bidder
Undertaking (To be submitted by all Bidders' on their letter head)

To,

The General Manager
HRDD
Sarva Haryana Gramin Bank
Head Office, Rohtak

We _____ (bidder name), hereby undertake that

- As on date of submission of tender, we are not blacklisted by the IRDAI/RBI/IBA and / or Central Government / any of the State Governments in India.
- We also undertake that; we are not involved in any legal case that may affect the solvency / existence of our company or in any other way that may affect capability to provide / continue the services to the Bank.
- We will not hold client responsible for any gaps in Reinsurance support and approvals. (Insurer will not deny coverage due to lack of Reinsurance capacity or approval once the bid is opened).

Yours faithfully,

Authorized Signatory

(Name, Designation and Seal of the Company)

Part II

Terms and conditions related to Coverages for the renewal of Insurance policy

Annexure I

- TAILOR MADE GROUP MEDICLAIM INSURANCE FOR EXISTING STAFF OF SARVA HARYANA GRAMIN BANK.

Sr. No.	INSURANCE COVERAGES	
1.	Family Floater	Yes
2.	Coverage	Existing Staff and their dependent family members
3.	No of Employees	**All Officers : 2103** **Office Assistants /Attendants : 1231**
4.	Total No of Employees & Lives	**3334 Employees** **12904 Lives (Tentative)**
5	Family Definition	Staff + Spouse + Dependent Children + any two of the Dependent Parents /Parents-in-law + Any dependent Sibling as well. (As per below definition) •Dependent children, including step children and legally adopted children are covered. •Widowed daughter and dependent divorced/ separated daughters, sisters including unmarried / divorced / abandoned or separated from husband/ widowed sisters and crippled child/ brother shall be considered as dependent for the purpose of this policy. •Special abled brother / sister with 40% or more disability shall also be covered as dependents for the purpose of this policy. •No Age limit for dependent Parents. Any two, i.e. either dependent parents or parents-in-law will be covered as dependent for the purpose of the policy.
6	The Officers/ Employees in service would be continued beyond their retirement/ superannuation/ resignation, etc. until the end of the policy period.	Yes

7	**Sum Insured**	**All Officers : Rs. 4.00 Lakhs** **Office Assistants & : Rs .3.00 Lakhs** **Office Attendants**
8	Additional Sum Insured for Critical Illness	Rs.1.00 Lakh Only for the Officer / Employee (SELF ONLY)
9	Corporate Buffer	**Rs.50 lakhs**
10	Pre-existing Diseases	Covered from day 1 without any deletion
	Waiting period Waivers i.e. 30 days, 1, 2, & 4 years.	Waived Off
11	Fixed Room Rent for normal	Rs.5,000/-
12	Fixed Room Rent for ICU	Rs.7,500/-
13	Proportionate deductions	Waived off
14	Maternity cover	Covered as per below limits
	a) for Normal	Rs.50,000/-
	b) For C section	Rs.75,000/-
15	Covid-19	Covered
16	Termination of Pregnancy	Covered, if recommended by the Doctor
17	New Born baby	Covered from Birth
18	Pre and Post Hospitalization	30 and 90 days
19	Domiciliary and OPD treatment, Domiciliary Hospitalization	Covered up to Maximum Sum Insured
20	Ambulance Charges	Rs.2, 500/- in case of emergency.
21	Congenital anomalies cover	Internal diseases/defect anomalies are covered
22	Addition &Deletion	Pro rata (Date of Joining &Date of discharge from the Bank is considered) subject to sufficient balance in the CD account for any addition or from the date of premium remittance.
23	Day care Procedures	Covered.
24	Cataract Surgery	Rs.50,000/- per Eye
25	GST	Covered
26	Physiotherapy treatment	Covered, for the period specified by the recommended Doctor
27	Organ Donor cover	Covered (excluding organ cost)

28	Expenses on Major surgeries/ Illnesses	No capping
29	**Addition of Missed out Dependents not after claim**	**Facility of adding missed dependents (Parents / Spouse / Siblings/ any Children) to be provided up to 31st July 2024.** **AND** **There is no restriction on children addition in the policy throughout the Policy Period for baby born after 1st March 2024 and other dependents additions within** 30 **days of new joinees, newly married spouses etc**. **No additional premium to be charged for any dependent addition as the premium is charged on per Family Basis.**
30	Submission of claim documents for reimbursement	Within 30days from the discharge.
31	Intimation of claim	Within 30 days from the date of admission
32	Third Party Administrator	To be decided by the Bank at the time of placement of the policy

Claims Details of Last 3 Years:

Policy Period	No. of Lives Covered	Premium	Claim Amount (Paid+ O/S)	Claim Ratio
31st March 2021 to 30th March 2022	10933	4,89,37,116	4,73,31,552	96.72%
31st March 2022 to 30th March 2023	11730	5,91,07,675	5,41,03,975	91.53%
31st March 2023 to 30th March 2024 (Claims as on 19th March 2024)	**12904 Tentative**	5,79,84,086	6,28,63,274	108%

Corporate Buffer Utilized in last 3 Years

F.Y.	Amount (In INR)
2021-22	20,46,506
2022-23	8,27,455
2023-24 (As on 20th Feb 2024)	18,65,373

Annexure::II – Policy Wordings

Medical Scheme for the Officers/ Employees of Sarva Haryana Gramin Bank

1 RECITAL CLAUSE

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

1.2 OPERATIVE CLAUSE

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

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

1.3 The scheme covers expenses of the officers / employees and dependents in cases he/she shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/ Medical Specialist/ Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalization/ domiciliary hospitalization and domiciliary treatment expenses as defined in the Scheme, for medical/ surgical treatment at any Nursing Home/ Hospital / Clinic (for domiciliary treatment)/ Day care Centre which are registered with the local bodies, in India as herein defined (hereinafter called HOSPITAL) as an inpatient or otherwise as specified as per the scheme, to the extent of the sum insured + Corporate buffer.

1.0 The Scheme Covers Employee + Spouse + Dependent Children + 2 dependent Parents /parents-in-law + Dependent Sibling

1.1 No age limit for dependent children. (Including step children and legally adopted children) A child would be considered dependent if the monthly income does not exceed Rs. 12,000/- per month; which is at present, or revised by Indian Banks' Association in due course. Widowed Daughter and dependent divorced / separated daughters, sisters including unmarried / divorced / abandoned or separated from husband/ widowed sisters and Crippled Child shall be considered as dependent for the purpose of this policy. Physically challenged Brother / Sister with 40% or more disability.

2.2 No Age Limits for Dependent Parents. Either Dependent Parents or parents-In-law will be covered. Parents would be considered dependent if their monthly income does not exceed Rs.12, 000/- per month.

2.3 All New Officers / employees and their dependents to be covered from the date of joining as per their appointment letter if the sufficient balance is deposited with the Insurance Company or from date of premium remittance.

1.4 For additions /deletions during policy period, premium to be charged /refunded on pro rata basis.

1.5 Continuity benefits coverage to officers / employees on retirement and also to the Retired Officers / employees, who may be inducted in the Scheme.

1.6 In case of a death of employee/ officer the dependents will be in force in the policy till the expiry of the policy.

1.7 Sum Insured: Hospitalization and Domiciliary Treatment coverage as defined in the scheme per annum

Officers : Rs.4.00 Lakhs
Clerical Staff : Rs.3.00 Lakhs
Sub Staff : Rs.3.00 Lakhs

1.8 Change in sum insured after commencement of policy to be considered in case of promotion of the employee or vice versa.

1.9 Corporate buffer: Rs.50.00 Lakhs

- BUFFER CAN BE UTILISED FOR EXCESS AMOUNT OVER AND ABOVE THE SUM INSURED PER EMPLOYEE.

- Buffer can be asked by Bank senior authorities any time throughout the year and Insurance Company will not deny for the same, irrespective of the date of admission.

1.10 Basic Cover

a. In the event of any claim becoming admissible under this scheme, the company will pay to the Hospital/Nursing Home or Insured Person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and medically necessary incurred thereof by or on behalf of such insured person but not exceeding the Sum Insured in aggregate mentioned in the Schedule hereto.
b. Room and boarding expenses as provided by the Hospital/Nursing Home not exceeding per day limit as mentioned in the Schedule or the actual amount whichever is less.
c. Intensive care Unit (ICU) expenses not exceeding per day limit as mentioned in the Schedule or actual amount whichever is less.
d. Surgeon, team of surgeons, Assistant surgeon, Anaesthetist, Medical Practitioner Consultants, Specialists Fees.
e. Nursing Charges, Service Charges, IV Administration Charges, Nebulization Charges, RMO Charges, Aesthetic, Oxygen, Blood, Operation Theatre Charges, surgical appliances, OT Consumables, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Defibrillator Ventilator, Orthopaedic implants, Cochlear Implant, any other implant, Intra-Ocular Lenses, infra cardiac valve replacements, vascular stents, any other valve replacement, Laboratory/Diagnostic tests, X-ray CT Scan, MRI, any other scan and such similar expenses that are medically necessary, or incurred during hospitalization as per the advice of the attending doctor.
f. Hospitalization expenses {excluding cost of organ} incurred on donor in respect of organ transplant to the insured.
g. Pre-Hospitalization and Post- Hospitalization Expenses — Medical Expenses relevant to the same condition for which the hospitalization is required incurred during the period up to 30 days prior to hospitalization and during the period up to 90 days after the discharge from the hospital. These expenses are admissible only if the primary hospitalization claim is admissible under the policy.

2**. Definitions**:

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

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

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

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

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

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

1. Internal Congenital Anomaly

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

2. External Congenital Anomaly

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

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

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

2.9 DAY CARE CENTRE means any institution established for day care treatment of illness and/or injuries or a medical set —up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a. Has qualified nursing staff under its employment.

b. Has qualified Medical practitioner(s) in charge

c. Has a fully equipped operation theatre of its own where surgical procedures are carried out.

d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

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

Procedure which is –

i) Undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement and

ii) Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition.

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

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

2.13 DISCLOSURE TO INFORMATION NORM: The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

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

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

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

2.17 GRACE PERIOD means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre — existing diseases. Coverage is not available for the period for which no premium is received.

2.18 HOSPITAL/NURSING HOME means any institution established for in -patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

- Has qualified nursing staff under its employment round the clock.
- Has at least 10 in-patient beds in towns having a population of less than 10 Lacs and at least 15 in -patient beds in all other places.
- Has a qualified medical Practitioner(s) in charge round the clock.
- Has a fully equipped Operation Theatre of its own where surgical procedures are carried out.
- Maintains daily records of patients and makes these accessible to the insurance company authorized personnel.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

For Ayurveda, Unani, Siddha, Naturopathy and Homeopathy treatment, hospitalization expenses are admissible only when the treatment has been undergone in a hospital as defined in clause 3.3 below.

2.19 HOSPITALISATION means admission in a Hospital/Nursing Home for a minimum period of 24 In-patient care consecutive "In-patient care" hours except for the specified day care procedures/treatments, where such admission could be for a period of less than 24 consecutive hours. For the list of these specified day care procedures/treatments, please see 3.4.

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

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

2.21 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

(a) Acute Condition-Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery
(b) Chronic Condition-A chronic Condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    - It needs ongoing or long term monitoring through consultations, examinations, check-ups, and/or tests.
    - It needs ongoing or long term control or relief of symptoms.
    - It requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
    - It continues indefinitely.
    - It recurs or is likely to recur.

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

2.23 IN-PATIENT CARE means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

2.25 INTENSIVE CARE UNIT means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

2.28 MEDICAL EXPENSES means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

2.29 MEDICALLY NECESSARY TREATMENT is defined as any treatment, tests, medication, or stay in hospital or part of a stay in a hospital which

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

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

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

2.31 NETWORK PROVIDER means the hospital/nursing home or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

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

2.32 NEW BORN BABY: A new born baby means a baby born during the Policy Period aged between one day and 90 days, both days inclusive.

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

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

2.35 OPD (Out-patient) TREATMENT means the one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in -patient.

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

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

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

2.39 PRE-HOSPITALISATION MEDICAL EXPENSES

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

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

2.40 POST HOSPITALISATION MEDICAL EXPENSES

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

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

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

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

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

2.44 REASONABLE AND CUSTOMARY CHARGES

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

2.45 RENEWAL defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating-the renewal continuous for the purpose of all waiting periods.

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

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

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

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

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

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

3 ADDITIONAL COVERAGES:

3.1 **DOMICILIARY TREATMENT/ OPD TREATMENT**:

Medical expenses incurred in case of the following diseases which need domiciliary/OPD treatment as may be certified by the attending medical practitioner and /or bank's medical officer shall be deemed as hospitalization expenses and reimbursed to the extent of 100% subject to the overall limit of Sum Insured under the policy:

1. Accidents of Serious Nature
2. Addison's Disease
3. All Animal/reptile/insect bite or sting
4. All Seizure disorders
5. Any organ related (chronic) condition
6. Aplastic Anemia
7. Arthritis
8. Autoimmune Myositis
9. Autoimmune vasculitis
10. Approved targeted therapies for treatment of Cancer in day care and on standalone basis. (Immunotherapy — Monoclonal Antibody Cancer treatment on standalone basis).
11. Cancer
12. Cardiac Ailment.
13. Celiac Disease
14. Cerebral Palsy
15. Chronic obstructive Pulmonary Disea a Bronchitis, Asthma
16. Chronic Pancreatitis
17. Connective tissue disorder
18. Diabetes and its complications (including Type 1Diabetes)
19. Diphtheria
20. Epidermolysis bullosa
21. Expenses incurred on radiotherapy and chemotherapy in the treatment of cancer and leukaemia
22. Glaucoma
23. Grave's Disease
24. Growth disorders
25. Haemorrhages caused by accidents
26. Hashimoyo's Thyroiditis
27. Hemophilia
28. Hepatitis -B,Hepatitis-C
29. Hypertension
30. Hypothyroidism, hyperthyroidism
31. Inflammatory Bowel Disease
32. Kidney Ailment
33. Leprosy
34. Leukemia
35. Malaria
36. Multiple Sclerosis/Motor Neuron Disease
37. Muscular dystrophies
38. Myasthenia gravis
39. Non — Alcoholic Cirrhosis of Liver
40. Osteoporosis
41. Paralysis
42. Parkinsons's Diseases
43. Pernicious Anemia
44. Physiotherapy
45. Pleurisy
46. Polio
47. Psoriasis/Psoriatic Arthritis

48. Psychiatric disorder including Schizophrenia and Psychotherapy
49. Purpura
50. Rheumatoid Arthritis (RA)
51. Sickle cell disease ,systemic lupus erythematous (SLE)
52. Sjogren's Syndrome
53. Sleep apnea syndrome (not related to obesity)
54. Status asthamaticus , sequalea of neningitis
55. Swine flu
56. System Lupus Erythematous
57. Thalassemia
58. Third Degree burns
59. Thrombo embolism venous thrombosis/venous thrombo embolism (VTE)
60. Treatment for Age related Macular Degeneration (ARMD) and Intra Vitreal injections for eye disorders other than ARMD also.
61. Tuberculosis
62. Tumor
63. Typhoid
64. Ulcerative Colitis
65. Varicose veins
66. Venous Thrombosis (not caused by smoking)
67. Wilson's disease
68. All strokes leading to paralysis.
69. Chikungunya
70. Dengue Fever

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

Other Terms & Conditions

I. For domiciliary / OPD claims duly attested copy of the prescription by the Bank competent Authority shall be considered for processing the claims. Insurance company/ TPA will not ask for original prescription for settlement of any claim.
II. Original films/ X rays and other kind of sensitive report which is required for a further treatment will not asked from the Insured and Insurance Company shall authorize TPA representative who is sitting in the bank premises to seen only and confirm to the TPA / Insurance company for further processing of claims without any objection on the same.

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

A) The condition of the patient is such that he/she is not a condition to be removed to a hospital

or

B) The patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

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

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

1	Adenoidectomy	20	Haemo dialysis
2	Appendectomy	21	Fissurectomy/Fistulectomy
3	Ascitic/Pleural tapping	22	Ascitic/Pleural tapping
4	Auroplasty not Cosmetic in nature	23	Hydrocele Surgeries
5	Coronary/Renal Angiography	24	Hysterectomy
6	Coronary angioplasty	25	Inguinal/ventral/mbilical/femoral hernia surgeries
7	Dental Surgery	26	Dental Surgery
8	D&C	27	Polypectomy
9	Excision of cyst/granuloma/lump/tumor	28	Septoplasty
10	Septoplasty	29	Piles/Fistula Surgeries
11	Piles/Fistula Surgeries	30	Prostate surgeries
12	Radiotherapy	31	Sinusitis surgeries
13	Chemotherapy	32	Tonsillectomy
14	Lithotripsy	33	Liver aspiration
15	Incision and drainage of abscess	34	Sclerotherapy
16	Varicocelectomy	35	Varicose Vein Ligation
17	Wound Suturing	36	All scopes along with biospies
18	FESS 37	37	Lumbar puncture

19	Operations/Micro Surgical operations on the nose, mouth, middle ear/internal ear, tongue, face, tonsils & adenoids , salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female/male sexual organs.	38	Approved targeted therapies for treatment of Cancer in day care and on standalone basis (Immunotherapy -- Monoclonal Antibody Cancer treatment on standalone basis).
		39	Treatment for Age related Macular , Degeneration (ARMD) and Intra ,Vitreal injections for eye , disorders other than ARMD also.

Day care procedures – Tentative List	
ENT: Operation of the ear	
1	Stapedotomy or Stapedectomy
2	Myringoplasty (Type -I Tympanoplasty)
3	Tympanoplasty (closure of an eardrum perforation)
4	Reconstruction and other Procedures of the auditory ossicles
5	Myringotomy
6	Removal of a tympanic drain
7	Mastoidectomy
8	Reconstruction of the middle ear
9	Fenestration of the inner ear
10	Incision (opening) and destruction (elimination) of the inner ear
ENT: Procedures on the nose & the nasal sinuses	
11	Excision and destruction of diseased tissue of the nose
12	Procedures on the turbinates (nasal concha)
13	Nasal sinus aspiration
ENT: Procedures on the tonsils & adenoids	
14	Transoral incision and drainage of a pharyngeal abscess
15	Tonsillectomy and / or adenoidectomy
16	Excision and destruction of a lingual tonsil
17	Quinsy drainage
OPTHALMOLOGY: Procedures on the eyes	
18	Incision of tear glands
19	Excision and destruction of diseased tissue of the eyelid

20	Procedures on the canthus and epicanthus
21	Corrective surgery for entropion and ectropion
22	Corrective surgery for blepharoptosis
23	Removal of a foreign body from the conjunctiva
24	Removal of a foreign body from the cornea
25	Incision of the cornea
26	Procedures for pterygium
27	Removal of a foreign body from the lens of the eye
28	Removal of a foreign body from the posterior chamber of the eye
29	Removal of a foreign body from the orbit and eyeball
30	Operation of cataract
31	Chalazion removal
32	Glaucoma Surgery
33	Surgery of Retinal Detachment
Procedures on the skin & subcutaneous tissues	
34	Incision of a pilonidal sinus
35	Other incisions of the skin and subcutaneous tissues
36	Surgical wound toilet (wound debridement)
37	Local excision or destruction of diseased tissue of the skin and subcutanous tissues
38	Simple restoration of surface continuity of the skin and subcutanous tissues
39	Free skin transplantation, donor site
40	Free skin transplantation, recipient site
41	Revision of skin plasty
42	Restoration and reconstruction of the skin and subcutaneous tissues
43	Chemosurgery to the skin
44	Excision of Granuloma 17
45	Incision and drainage of abscess
Procedures on the tongue	
46	Incision, excision and destruction of diseased tissue of the tongue
47	Partial glossectomy
48	Glossectomy
49	Reconstruction of the tongue
Procedures on the salivary glands & salivary ducts	
50	Incision and lancing of a salivary gland and a salivary duct

51	Excision of diseased tissue of a salivary gland and a salivary duct
52	Resection of a salivary gland
53	Reconstruction of a salivary gland and a salivary duct
Procedures on the mouth & face	
54	External incision and drainage in the region of the mouth, jaw and face
55	Incision of the hard and soft palate
56	Excision and destruction of diseased hard and soft palate
57	Incision, excision and destruction in the mouth
58	Plastic surgery to the floor of the mouth
59	Palatoplasty
Trauma surgery and orthopaedics	
60	Incision on bone, septic and aseptic
61	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
62	Suture and other Procedures on tendons and tendon sheath
63	Reduction of dislocation under GA
64	Arthroscopic knee aspiration
65	Aspiration of hematoma
66	Excision of dupuytren's contracture
67	Carpal tunnel decompression
68	Surgery for ligament tear
69	Surgery for meniscus tear
70	Surgery for hemoarthrosis /pyoarthrosis
71	Removal of fracture pins/nails
72	Removal of metal wire
73	Joint Aspiration - Daignostic / therapeutic
Procedures on the breast	
74	Incision of the breast
75	Procedures on the nipple
76	Excision of breast lump /Fibro adenoma
Procedures on the digestive tract	
77	Incision and excision of tissue in the perianal region
78	Surgical treatment of anal fistulas
79	Surgical treatment of haemorrhoids
80	Division of the anal sphincter (sphincterotomy)

81	Ultrasound guided aspirations
82	Sclerotherapy
83	Therapeutic Ascitic Tapping
84	Endoscopic ligation /banding
85	Dilatation of digestive tract strictures
86	Endoscopic ultrasonography and biopsy
87	Replacement of Gastrostomy tube
88	Endoscopic decompression of colon
89	Therapeutic ERCP 18
90	Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux Disease
91	Endoscopic Gastrostomy
92	Laparoscopic procedures e.g. colecystectomy, appendicectomy etc.
93	Endoscopic Drainage of Pseudopancreatic cyst
94	Hernia Repair (Herniotomy / herniography / hernioplasty)
Procedures on the female sexual organs	
95	Incision of the ovary
96	Insufflation of the Fallopian tubes
97	Dilatation of the cervical canal
98	Conisation of the uterine cervix
99	Incision of the uterus (hysterotomy)
100	Therapeutic curettage
101	Culdotomy
102	Local excision and destruction of diseased tissue of vagina and Pouch of Douglas
103	Procedures on Bartholin’s glands (cyst)
104	Endoscopic polypectomy
105	Myomectomy , hysterscopic or laparascopic biopsy or removal
Procedures on the prostate & seminal vesicles	
106	Incision of the prostate
107	Transurethral excision and destruction of prostate tissue
108	Open surgical excision and destruction of prostate tissue
109	Radical prostatovesiculectomy
110	Incision and excision of periprostatic tissue
Procedures on the scrotum & tunica vaginalis testis	
111	Incision of the scrotum and tunica vaginalis testis

112	Operation on a testicular hydrocele
113	Excision and destruction of diseased scrotal tissue
114	Plastic reconstruction of the scrotum and tunica vaginalis testis
Procedures on the testes	
115	Incision of the testes
116	Excision and destruction of diseased tissue of the testes
117	Orchidectomy- Unilateral / Bilateral
118	Orchidopexy
119	Abdominal exploration in cryptorchidism
120	Surgical repositioning of an abdominal testis
121	Reconstruction of the testis
122	Implantation, exchange and removal of a testicular prosthesis
Procedures on the spermatic cord, epididymis and DuctusDeferans	
123	Surgical treatment of a varicocele and hydrocele of spermatic cord
124	Excision in the area of the epididymis
125	Epididymectomy
126	Reconstruction of the spermatic cord
127	Reconstruction of the ductus deferens and epididymis
Procedures on the penis	
128	Procedures on the foreskin
129	Local excision and destruction of diseased tissue of the penis
130	Amputation of the penis
131	Plastic reconstruction of the penis
Procedures on the urinary system	
132	Cystoscopical removal of stones
133	Lithotripsy 19
134	Haemodialysis
135	PCNS (Percutaneous nephrostomy)
136	PCNL (PercutanousNephro-Lithotomy)
137	Tran urethral resection of bladder tumor
138	Suprapubiccytostomy
Procedures of Respiratory System	
139	Brochoscopic treatment of bleeding lesion
140	Brochoscopic treatment of fistula /stenting

141	Bronchoalveolar lavage & biopsy
142	Direct Laryngoscopy with biopsy
143	Therapeutic Pleural Tapping
Procedures of Heart and Blood vessels	
144	Coronary angiography (CAG)
145	Coronary Angioplasty (PTCA)
146	Insertion of filter in inferior vena cava
147	TIPS procedure for portal hypertension
148	Blood transfusion for recipient
149	Therapeutic Phlebotomy
150	Pericardiocentesis
151	Insertion of gel foam in artery or vein
152	Carotid angioplasty
153	Renal angioplasty
154	Varicose vein stripping or ligation
OTHER Procedures	
155	Radiotherapy for Cancer
156	Cancer Chemotherapy (Advance Cancer Treatment VIZ.Adjuvant / Neo Adjuvant Therapy including Zoledronic Acid injection is covered with or without hospitalization).
157	True cut Biopsy
158	Endoscopic Foreign Body Removal
159	Vaccination / Inoculation - Post Dog bite or Snake bite
160	Endoscopic placement/removal of stents
161	Tumorembolisation
162	Aspiration of an internal abscess under ultrasound guidance

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

A) The treatment is undertaken under General or Local Anesthesia in a hospital/day care Centre in less than a day because of technological advancement.
B) Which would otherwise require hospitalization of more than a day.

3.5 MATERNITY EXPENSES BENEFIT EXTENSION

We will pay the Maternity Expenses for the delivery of a child and/or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy during the Policy Year. The maximum benefit available allowable under this clause will be upto Rs. 50,000/- for Normal Delivery and Rs. 75000/- for Caesarean Section- The hospitalization expenses in respect of the new born child will be covered within the Mother's Maternity expenses.

Special conditions applicable to Maternity Expenses Benefit Extension:

i) No waiting period for 9 months under Maternity benefit.
ii) Pre-natal and Post-natal charges in respect of Maternity benefit are not covered.
iii) Missed Abortions, Miscarriage, Medical termination of pregnancy or abortions induced by accidents are covered under the limit of maternity expenses.
iv) Complications in Maternity including operations for extra uterine/ectopic pregnancy would be covered up to Sum Insured + Corporate buffer.
v) Maternity Expenses Benefit Extension is allowable irrespective of the number of living children.

3.6 BABY DAY ONE COVER

New born baby is covered from day one. All expenses incurred on the new born baby during maternity will be covered up to Rs. 20,000/- per child, in addition to the Maternity limit. However, if the baby contracts any illness the same shall be considered in the Sum Insured + Corporate Buffer. Baby to be taken as an additional member within the normal family floater.

3.7 AMBULANCE CHARGES

Ambulance charges are payable up to Rs. 2500 per trip to hospital and/or transfer to another hospital or

Transfer from hospital to home if medically advised. Taxi and Auto expenses in actual maximum up to

Rs. 750 per hospitalization.

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

3.8 PRE EXISTING DISEASES/AILMENTS

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

3.9 CONGENITAL ANOMALIES

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

3.10 PSYCHIATRIC DISEASES

Expenses for treatment of psychiatric and psychosomatic diseases will be payable with or without

Hospitalization up to the sum insured.

3.11 ADVANCED MEDICAL TREATMENT

New advanced medical procedures approved by the appropriate authority eg. Laser surgery, stem cell therapy

For treatment of a disease is payable on hospitalization/day care surgery.

All advance/modern treatment is covered under the policy up to the Sum Insured without any capping.

3.12 Treatments taken for accidents can be payable even on OPD basis in a hospital up to Sum Insured

3.13 TAXES AND OTHER CHARGES

All Taxes, Surcharges, Service charges, Registration charges, Admission Charges, Nursing, and Administration charges to be payable. Charges for diapers and sanitary pads are payable if

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

3.14Treatment for Genetic disorder and stem cell therapy is covered under the scheme.

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

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

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

3.18 PHYSIOTHERAPY CHARGES: Physiotherapy charges shall be covered for the period specified by the medical practitioner even if taken at home. All claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the sum insured stated in the schedule and Corporate Buffer if allocated.

4. EXCLUSIONS:

The company shall not be liable to make any payment under the policy in respect of any expenses

Whatsoever incurred by the insured person in connection with or in respect of:

4.1. Investigation& Evaluation

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.2. Rest Cure, Rehabilitation and Respite Care

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or nen-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.3. Change-of-Gender Treatments

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

4.4. Stay in Hospital which is not Medically Necessary.

4.5. Self-Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

4.6. Birth control, Sterility and Infertility

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

4.7. Refractive Error -Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

4.8. Unproven Treatments

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.9. Drug/Alcohol Abuse

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

4.10. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses

4.11. Home Visit Charges

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

4.12. Breach of Law

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

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

4.14

a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.

b. Vaccination or Inoculation

c. Change of life or cosmetic or aesthetic treatment of any description is not covered.

d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

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

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

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

4.18 All expenses arising out of any condition directly or indirectly caused to or associated with Human T Cell Lymphotropic Virus Type Ill (HTLB — lll) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome of a similar kind commonly referred to as AIDS.

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

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

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

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

4.23 Expenses on purchase of medicine not supported by bills/receipts/cash memos with valid GST No of the issuer of such bills/receipts/cash memos.

5**. Claims Procedure**

A. Claims Administration and Process

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

1. On the occurrence or discovery of an illness or injury that may give rise to a claim under this policy, the claims procedure set out below shall be followed.

2. The treatment should be taken as per the advice, directions and guidance of the treating medical practitioner. Any failure to follow such advice, directions and guidance will prejudice the claim.

3. The insured person must submit to medical examination by our medical practitioner in case requested by us and at our cost, as often as we consider reasonable and necessary and we/our representatives must be permitted to inspect the medical and hospitalization records pertaining to the insured person's treatment and to investigate the circumstances pertaining to the claim.

4. We and our representatives must be given all reasonable cooperation in investigating the claim in order to assess our liability and quantum in respect of the claim.

Notification of Claim

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

B**. Procedure for cashless claims**

1. Cashless facility for treatment shall be available to insured in network hospitals only.

2. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network providers/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company and the TPA mentioned in the schedule

3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.

4. On admission in the network provider/PPN, produce the ID card issued by the TPA at the hospital helpdesk. Cashless request form available with the network provider/PPN and TPA

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

i. The health card which the insurer or the associated TPA has issued to the insured person supported with KYC documents;

ii. The Policy Number;

iii. Name of the Policy Number/Employer;

iv. Name and address of insured person/Employee/member in respect of whom the request is being made;

v. Nature of the illness/injury and the treatment/surgery required;

vi. Name and address of the attending Medical Practitioner;

vii. Hospital where the treatment/Surgery is proposed to be taken;

viii. Proposed date of admission;

5. If these details are not provided in full or sufficient or are insufficient for the associated TPA to consider the request, the associated TPA will request additional information or documentation in respect of that request.

6. When the associated TPA has obtained sufficient details to access the request, the associated TPA will issue the authorization letter specifying the specified amount, any specific limitation on the claim, applicable deductibles, and non-payable items if applicable, or we may reject the request for pre-authorization specifying reason for the rejection.

7. The TPA upon getting cashless request form and related medical information from the insured person/network hospital/PPN shall issue pre-authorization letter to the hospital after verification.

8. Once the request for pre-authorization has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, hospitals and locations match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre-authorized by the associated TPA, the associated TPA will make the payment of the amounts assessed to be due directly to the Network Provider.

9. In the event that the cost of hospitalization exceeds the authorized limits as mentioned in the authorizations letter:

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

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

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

11. at the time of discharge:

a. The Network Provider may forward a final request for authorizations for any residual amount to the TPA along with the discharges summary and the detailed bill break up in accordance with the process described at 5.B above.

b. Upon receipt of the final authorizations letter from TPA, the insured person may be discharged by the Network Provider.

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

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

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

C. Procedure for reimbursement of claims

In non-network hospitals payment must be made upfront and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/the bank's office authorized to deal with Health Claims within the prescribed time limit. For all claims for which Cashless Facilities have not been pre-authorized or for which treatment has not been taken at a Network Provider, We shall be given written notice of the claim along with the following details within the timelines as mentioned for reimbursement claims in B above:

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

D. Documents

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

i Duly completed claim form

ii. Photo ID and Age Proof

iii. Health Card, Policy copy, Photo ID and KYC documents

iv. Attending medical practitioner's/surgeon's certificate regarding diagnosis/nature of operation performed along with date of diagnosis, investigation test reports etc. supported by the prescription from attending medical practitioner

v. Original discharge card/day re summary/transfer summary

vi. Original final hospital bill with all origin deposit and final payment receipt

vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e. lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery

viii. All previous consultation papers indicating history and treatment details for current ailment

ix. All original diagnostic reports (including imaging and laboratory) along with medical practitioner's prescription and bill/invoice with receipt from diagnostic centre.

x. All original medicine/pharmacy bills along with medical practitioner's prescription;

xi. MLC /FIR copy- in Accidental case only;

xii. Copy of death summary and copy of death certificate (in death claims only);

xiii. Pre and post-operative imaging reports-in Accidental cases only;

xix. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;

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

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

E. Scrutiny of Claim Documents

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

b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

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

F. Claim Assessment

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

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

I. If any Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/Certificate of Insurance, our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.

II. Opted Deductible (Pre Claim/ Aggregate/ Corporate), if any, shall be applicable on the amount payable by Us after applying (lI), and (ii) above.

lll. Co-Payments if any, shall be applicable on the amount payable by us after applying (i), and (ii). The Claim amount assessed under Section 5.F (i), (ii) and (iii) will be deducted from the following amounts in the following progressive order after applying Sub Limit.

a. Sum Insured

b. Corporate Buffer

G. Claim Settlement

1. On receipt of the final document(s), the company shall within a period of 24 (Twenty Four) days Offer a settlement of the claim to the insured person.

2. In the cases of delay in the payment, the company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate that is 2%(Two percent) above the bank rate prevalent at the beginning of the financial year in which the claim is paid.

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

4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is paid, from the date of receipt of last necessary document to the date of payment of claim.

5. The payment of the amount due shall be made by the company, upon acceptance of an offer of settlement as stated above by the insured person, within 7(Seven) days from the date of acceptance of the offer.

6. A claim, which is not covered under the policy cover and conditions, can be rejected.

H. Rejection/ Repudiation of Claim

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

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

I. Claim Payment Terms

I. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

II. All claims will be payable in India and in Indian rupees.

III We are not obligated to make payment for any claim or that part of any claim that could have been avoided of reduced if the Insured Person could have reasonable minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice of guidance provided by a Medical Practitioner.

IV. The Sum insured opted under the Policy shall be reduced by the amount payable/ paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

V. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

VI. For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

VII. For Reimbursement claims, the payment shall be made to the Insured person. In the unfortunate event of the Insured person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and case of no Nominee, to the legal heir who holds a succession certificate of indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

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

6 CONDITIONS

6.1 Disclosure of Information

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

6.2 Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

6.3Communication

i. All communication should be made in writing.

ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.

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

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

6.4 Physical Examination

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

6.5 Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are

used by against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Company. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Company or to induce the Company to issue an Insurance Policy:

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

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Company.

6.6 Territorial Limit

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

6.7 Renewal of Policy

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

Insured person.

i. The company shall endeavor 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. After the end of the policy period, the policy can be renewed within the Grace Period of 30 days to maintain continuity benefits without break in policy. Coverage is not available during the grace period.

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

6.8 Enhancement of Sum Insured:

Change in Sum Insured after commencement of policy to be considered in case of promotion of the employee of vice versa.

6.9 Guideline for Addition of members: -

Midterm additions are allowed only for natural additions subject to intimation received within 30 days, i.e. new joinees, newly married spouses.

Any additions for new employee, spouse would be allowed within 30 days of date of joining /marriage respectively.

There is no restriction on children addition in the policy throughout the Policy Period for baby born after 1st March 2024.

Bank will add any missing dependents up to 31st July 2024 in the policy with no cost for the same. As the data provided by Bank for the renewal process is tentative only.

6.10 Territorial Jurisdiction

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

6.11Maintenance of member Records

The Insured shall throughout the period of insurance keep and maintain a proper record of register containing

the names of all the Insured persons and other relevant details as are normally kept in any institution/

Organization. The Insured shall declare to the company any additions in the number of Insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

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

6.12 Arbitration

If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shell be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the arbitration and conciliation Act, 1996.

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

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

6.13 Disclaimer

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

6.14 IRDA Regulations

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

6.15 Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The insured person shall be notified three months before the changes are effected.

6.16 Withdrawal of Policy

In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy. Insured person will have the option to migrate to similar health insurance product available with the company at the time of renewal with all the accrued continuity benefits such as waiver of Waiting Period as per IRDAI guidelines, provided the policy has been maintained without a break.

Critical illness Benefit Cover

For the purpose of this Section, "Critical Illness" means any illness, medical event of surgical procedure as specifically defined whose signs or symptoms first commence since the commencement of the policy year. The benefits under this cover (as set out below) will be over and above the base sum insured.

The cover is applicable provided that the critical illness, which the insured person is suffering from, occurs or first manifests itself during the policy year as a first incidence.

Critical illness is to be provided to the employee subject to a sum insured of Rs. 1,00,000/-. The cover starts on inception of the policy. In case an employee contracts a critical illness as listed below, the total sum insured of Rs. 1, 00,000/- is paid, as a benefit. This benefit is provided on first detection/diagnosis of the critical illness.

A. List of Critical illnesses cover under this Benefit:

I**. Cancer of Specified Severity (Including Leukemia)**

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The terms cancer includes leukemia, lymphoma and sarcoma.

The following are excluded-

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, of non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1,CIN- 2, and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

a. Malignant melanoma that has not caused invasion beyond the epidermis;

b. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2ZNOMO.

c. All Thyroid cancers histologically classified as TLINOMO (TNM Classification) or below.

d. Chronic lymphocytic leukemia less than RAI stage 3.

e. Non-invasive papillary cancer of the bladder histologically described as TaNOMO or of a lesser classification.

f. All Gastro-Intestinal Stromal Tumors histologically classified as TINOMO (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.

g. All tumors in the presence of HIV infection.

II**. Stroke Resulting in Permanent Symptoms**

Any cerebrovascular incident producing permanent neurological sequela. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner

and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

III. **Permanent Paralysis of Limbs**

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

IV. Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist. The following are excluded: Angioplasty and/or any other intra-arterial procedures.

V. Myocardial Infarction (First Heart Attack of Specific severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria.

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes.

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded.

iv. Other acute Coronary Syndromes.

v. Any type of angina pectoris.

vi. A rise in cardiac biomarkers or Troponin T or | in absence of overt ischemic heart disease OR following an inter-arterial cardiac procedure.

VI. Open heart Replacement or Repair of Heart valves

The actual undergoing of open-heart valve surgery is to replace or repair one of more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

VII. Major organ/Bone Marrow Transplant

i. The actual undergoing of a transplant of:

a. One ofthe following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.

b. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

ii. The following are excluded:

a. Other stem-cell transplants.

b. Where only islets of Langerhans are transplanted.

VIII. Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

IX. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice.

ii. Ascites.

iii. Hepatic encephalopathy.

I. Liver failure secondary to alcohol or drug abuse is excluded

B. Cover

If an insured person is diagnosed to be suffering from any of the Critical Illnesses of the nature specified above during the policy year, then we will pay a Critical Illness Sum Insured specified in the policy schedule/certificate of insurance provided that:

a. Under this policy there would be no waiting period for the payment of the claim on the inception of the policy, nor any survival period for the payment of the claim on the individual contracting any of the above mentioned Critical Illness.

b. Upon our admission of the first claim under this benefit in respect of an insured person in any policy year, the cover under this benefit shall automatically terminate in respect of that insured person.

¢. Our total and cumulative liability in respect of an insured person under this benefit will be limited to the Critical Illness Sum Insured of Rs. 1,00,000/- only.

d. This benefit is paid as a lump sum amount and is over and above the base Sum Insured. Hospitalization is not required to claim this benefit. Further the employee can claim the cost of hospitalization on the same from the Group Mediclaim Policy as cashless/reimbursement of expenses for the treatment taken by him.

1) "Policy Issuing Office: ……"

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

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Annexure III

Service Level Agreement

This Service Level Agreement ("Agreement") is made and executed on_____day of_____2024 at Rohtak, Haryana, India.

BY AND BETWEEN

_____, a licensed Public/Private Sector General/ Standalone Health Insurance Company authorized and Regulated by the Insurance Regulatory and Development Authority (IRDA) under License CodeNo._____and having its registered office at

_____

Sarva Haryana Gramin Bank came into existence after amalgamation of 2 RRBs namely Haryana Gramin Bank, Head Office, Rohtak (Sponsored by Punjab National Bank) & Gurgaon Gramin Bank, Head Office, Gurgaon (Sponsored by Syndicate Bank) vide Notification dated 29.11.2013. At present, the Head Office of the Bank is at Rohtak. Sarva Haryana Gramin Bank operates in all 22 Districts of Haryana State. Sarva Haryana Gramin Bank is having 682 Branches all over Haryana.

The purpose of this agreement is to set forth the terms and understandings of both parties with respect to the provisions of client services by _____Insurance Company Limited duly appointed by Sarva Haryana Gramin Bank for the purpose of providing Group Mediclaim Insurance Coverage to the in-service employees/Retired employees and their dependents.

Tenure of Agreement

The Agreement will be for 1 year starting from the tentative Policy Inception date **01/05/2024 till 30/04/2025 00:00 hrs.**

NOW THEREFORE in consideration of the mutual covenants, terms and conditions set forth in this SLA, the Parties agree as follows:

1) Scope and responsibilities by Either Party:

Scope of Work	Responsible Party
Policy Document Issuance	_____Insurance Company Limited
Addition, Deletion & Correction of Member	_____Insurance Company Limited
Claims Management	_____Insurance Company Limited
Administration of policy	_____Insurance Company Limited

2) Policy Administration & Turn Around Timelines:

Service Administration	Turn Around TAT
Issuance of Policy document by Insurer	10 working days from the date of acceptance of premium
Issuance of Endorsement (Addition, Deletion & Correction)	10 working days
Settlement Amount Payment on Account post submission of complete documents	30 working days

2) Claims process: Sarva Haryana Gramin Bank is responsible for notifying claims or potential circumstances that may give rise to a claim in accordance with Sarva Haryana Gramin Bank's GMC Policy. To ensure full protection under Sarva Haryana Gramin Bank's GMC policy, Sarva Haryana Gramin Bank should familiarize themselves with the coverage conditions or other procedures immediately relating to claims and to the notification of those claims.
Collection of the Reimbursement Claim documents will be done weekly from designated regional offices of Sarva Haryana Gramin Bank by TPA/Insurer. Reimbursement Claim documents should be processed online from Rohtak, Haryana.

3) Turn Around Time envisaged for rendering service by Insurance Company/ Shortlisted TPA:

Service	Maximum Turn Around Time
E-Card Issuance	Within 5 working days
Physical Card Issuance	Within 10 working days
Cashless Approvals	Within 3 Hours
Processing of Reimbursement Claims	03 working days
Discharge Voucher	Within 10 Days
Resolution of Grievances	05 working days
Claims MIS	Monthly- By 5th day of the month
Claims Document collection by Insurance Company/ Shortlisted TPA representatives fromrespective Regional Offices of the Bank	Once in a week

4) Escalation matrices

The mechanism and escalation matrices for reporting of issues pertaining to claims and deficiency in services to be provided during issuance of the policy. Any escalations have to be given a detailed response within 3 days ofthe escalation. In case of non-adherence of the above clause, a penalty of 2% would be levied on the claim amount.

5) Grievance redressal committee

The insurer to provide grievance redressal within 3 working days.

There would be a monthly meet between decision makers at the insurer end and nominated personnel by the bank & representatives of ARIBL for addressing grievances where responses are not satisfactory.

Confidentiality

Both parties will treat information received from the other relating to this agreement and to the client's businessas confidential and will not disclose it to any other person not entitled to receive it except as may be necessary to fulfil their respective obligation in the conduct of this agreement and except as may be required by law or regulatory authority or information already in the public domain.

In witness where of the parties here to has set their respective hand and signed this deed with seal, on the day,month and year first above mentioned.

First Party

For and on behalf of

Sarva Haryana Gramin Bank Witness

Signature……... Signature:_____

Name…… Name:_____

Designation…… Designation……

Second Party

For and on behalf of

Insurance Company Limited Witness

Signature……... Signature:_____

Name…… Name:_____

Designation…… Designation……

Financial Bid Format

Details for Financial Bid for In Service Employee Policy

Description : Appointment of General Insurance Companies / Standalone Health Insurance Company for providing Group Mediclaim Policy of Sarva Haryana Gramin Bank for In-service Employees & their dependents.

Price Header	In-service Employees**	Premium Per Employee/Unit *	Total Premium (In Rs.)
(I)	(2)	(3)	(4) = (2) X (3)
Premium excluding GST to be mentioned for a Single Unit For Clerical and Sub-Staff Employees (In Rupees)	**1231**		
Premium excluding GST to be mentioned for a Single Unit For All Officers (in Rupees)	**2103**		
(A) Net Premium in Rupees (Without GST)			
(B) GST (in Rupees)			
Gross Total Premium (A+B) With GST			

*The term employee will include self and his/her dependents which will be defined as one unit.

** Data of in service employees shared above is indicative only and may vary due to New Joinees, Retirees and resignation and final count along with dependents details will be shared during the policy finalization.

Premium quoted above should be valid for period of one year and inclusive of stipulated IRDAI brokerage and TPA charges on Insurance Policies.

NOTE - Financial bid format is not to be submitted along with the technical bid documents.

Signature of Authorized Person with Company Seal