GROUP PERSONAL ACCIDENT
Policy Wordings

SECTION A) PREAMBLE

Our agreement to insure your employees/members (hereinafter called the 'Insured' or "Policyholder" or "Insured Person(s) or "Proposer"") "Insured Person(s)" named in the schedule hereto is based on your Proposal to Bajaj General Insurance Limited (Formerly known as Bajaj Allianz General Insurance Co. Ltd.) (hereinafter called the "Company" or "insurance company" or "Insurer" or "Bajaj General"), which is the basis of this agreement, and your payment of premium. This Policy records the entire agreement between us and sets out what we insure, how we insure it, and what we expect from you.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

1. **Accident, Accidental**
An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any one illness**
Any one Illness means continuous Period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3. **AYUSH Hospital:**
An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
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.

4. **AYUSH Day Care Centre:**
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health Centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s)on daycare basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out; Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. **Condition Precedent:**
Condition Precedent means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

6. **Cashless facility**
Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Insurer to the extent of pre-authorization is approved.

7. **Congenital Anomaly**
Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body.

8. **Co-Payment**
A co-payment means a cost-sharing requirement under a health insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

9. **Cumulative Bonus**
Cumulative Bonus means any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

10. **Day care centre**
A day care centre means any institution established for day care treatment of Illness and / or injuries or a medical set-up with 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,
   i. has qualified nursing staff under its employment,
   ii. has qualified medical practitioner(s) in charge,
   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

11. **Day Care Treatment**
Day care treatment means medical treatment, and/or surgical procedure which is:
   i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs 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.

12. Deductible

Deductible means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified amount (in INR) 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.
Deductible will be applicable either per year (Aggregate Deductible) or per claim, as specified in the Policy Schedule.

13. Dental Treatment

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

14. 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

15. Domiciliary Hospitalization

Domiciliary hospitalization means medical treatment for 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:

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

16. Emergency Care

Emergency care means management of an Illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured's health.

17. Grace Period:

Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

18. Hospital:

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under 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:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

19. Hospitalization:

Hospitalization means admission in a Hospital for a minimum period of 24 consecutive In patient Care hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

20. Illness

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

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

21. Injury/ Bodily Injury

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.

22. Inpatient Care

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

23. Intensive Care Unit

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.

24. ICU Charges

ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for

ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

25. **Maternity expenses:** Maternity expenses means
    i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

26. **Medical Advice:**
Medical advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

27. **Medical expenses:**
Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

28. **Medical Practitioner/ Physician:**
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy or Ayurvedic and or such other authorities set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

29. **Medically Necessary Treatment:**
Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    i. is required for the medical management of the illness or injury suffered by the Insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner,
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

30. **Migration**
Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

31. **New Born Baby**
New Born baby means baby born during the Policy Period and is aged up to 90 days.

32. **Network Provider**
Network Provider means Hospitals or health care providers enlisted by an Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a Cashless facility.

33. **Non-Network Provider** means any Hospital, day care centre or other provider that is not part of the network.

34. **Notification of Claim:** Notification of claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

35. **Notification of Claim:**
Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

36. **OPD treatment:**
OPD treatment means 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.

37. **Pre-Existing Disease:**
Pre-existing disease means any condition, ailment or injury or disease
That is/are diagnosed by a Physician within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement
Or
For which medical advice or treatment was recommended by, or received from, a physician/Medical Practitioner within 36 months prior to the effective date of the Policy issued by the Insurer or its reinstatement.

38. **Pre-hospitalization Medical Expenses**
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the Hospitalization of the Insured Person, 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 the Insurer.

39. **Post-hospitalization Medical Expenses**
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:
Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

40. **Portability:**
Portability means the right accorded to an individual health insurance policyholder (including all members under family cover) to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another.

41. **Qualified Nurse:**
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.

42. **Room rent**
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

44. **Renewal**
Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

45. **Surgery or Surgical Procedure**
Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

46. **Unproven/Experimental treatment**
Unproven/Experimental treatment means treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

SECTION B) DEFINITIONS- SPECIFIC DEFINITIONS

1. **AYUSH Treatment** refers to medical expenses incurred on hospitalisation under Ayurveda, Yoga and Naturopathy Unani, Siddha and Homeopathy systems

2. **Daily Allowance means** the amount and period specified in the Schedule.

3. **Limit of indemnity;** Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Schedule during the policy period and means the amount stated in the Schedule against each Cover and subject to the limits specified in Section C

4. **Named insured/ insured:** Insured means the persons, or his Family members, named in the Schedule.

5. **Nominee**; Nominee is the person selected by the policyholder to receive the benefit in case of death of the insured thus giving a valid discharge to the insurer on settlement of claim under an insurance policy.

6. **Occupation –** Your occupation as shown in the schedule.

7. **Policy Period** – The period between and including the start and end dates shown in the schedule.

8. **Proposal** The proposal form and other information and documentation supplied to us in considering whether and on what terms to offer this insurance.

9. **Permanent Total Disability**
Disability Certificate from Civil Surgeon of Government Hospital stating the continuous and permanent:
   i. loss of the sight of both eyes
   ii. physical separation of or the loss of ability to use both hands or both feet
   iii. physical separation of or the loss of ability to use one hand and one foot
   iv. loss of sight of one eye and the physical separation of or the loss of ability to use either one hand or one foot

10. **Permanent Partial Disability**
Disability Certificate from Civil Surgeon of Government Hospital stating the total and continuous loss or impairment of a body part or sensory organ, with the percentage of disability

11. **Policy** – This Policy Document, the Schedule and Proposal

12. **Schedule** – The Schedule and any Annexure or Endorsement to it which sets out your personal details, the type of insurance cover in force and the sum assured.

13. **You, Your Family member(s), Your Yourself**: The person or persons we insure as set out in the Schedule.

14. **We, Our, Ours, Us** – The Bajaj General Insurance Limited**.**

SECTION C) COVERAGE

What we will pay for

Our liability to make payment for one or more of the events described at 1) to 4) below is limited to the Total Sum Assured of the Insured Person(s) for whom the claim has been preferred, except as we have agreed at 2)

You agree that we shall deduct from any amount we have to pay under 1) to 4) any amount we have already paid under any of 1) to 4), so that our total payments do not exceed the Total Sum Assured of the Insured Person(s) for whom the claim has been preferred. However, if we become liable to make payment under 1) or 2), then this insurance will cease as far as the Insured Person(s) for whom the claim has been preferred.

1. **Death (Available if the schedule shows you opted for it)**
We will pay the Nominee 100% of the sum assured shown under the schedule headings Basic, Wider and Comprehensive if during the Policy Period the Insured Person (s) meets with Accidental Bodily Injury that causes death within 12 months.

2. **Permanent Total Disability (Available if the schedule shows you opted for it)**
We will pay the Insured (employer) /Insured Person 125% of the sum assured shown under the Schedule headings Wider and Comprehensive if the Insured Person(s) meets with Accidental Bodily Injury during the Policy Period that causes Permanent Total Disability within 12 months.

3. **Permanent Partial Disability (Available if the schedule shows you opted for it)**
If the Insured Person(s) meets with Accidental Bodily Injury during the Policy Period that causes Permanent Partial Disability within 12 months, we will pay the percentage shown in the table below applied to the sum assured shown under the Schedule headings Wider and Comprehensive of the Insured Person(s).

An arm at the shoulder joint	70%
An arm above the elbow joint	65%
An arm beneath the elbow joint	60%
A hand at the wrist	55%
A thumb	20%
An index finger	10%
Any other finger	5%
A leg above mid-thigh	70%
A leg up to mid-thigh	60%
A leg up to beneath the knee	50%
A leg up to mid-calf	45%
A foot at the ankle	40%
A large toe	5%
Any other toe	2%
An eye	50%
Hearing of one ear	30%
Hearing of both ears	75%
Sense of smell	10%
Sense of taste	5%

a. If the Permanent Partial Disability is not listed in the table, then we will pay a proportion of the sum assured shown under the schedule headings Wider and Comprehensive. You agree that the amount payable by us will be decided by our medical advisors according to the degree to which the normal functional physical capacity of the Insured Person(s) has been impaired permanently

b. If the Insured Person(s) was already suffering from Permanent Partial Disability before the date the Insured Person(s) met with Accidental Bodily Injury, then the amount we pay will be reduced by that extent. You agree that the reduction will be decided by our medical advisors according to the degree of Permanent Partial Disability from which the Insured Person(s) was already suffering.

4. **Temporary Total Disability (Available if the schedule shows you opted for it)**
If the Insured Person(s) suffers Accidental Bodily Injury during the Policy Period which completely prevents the Insured Person(s) from engaging in his/ her occupation, then we will make a weekly payment of the lower of 1% of the sum assured shown under the schedule heading Comprehensive (of the Insured Person(s) and Rs 5,000/- per week)

a. We will make the first payment when you satisfy us that Accidental Bodily Injury has completely prevented the Insured Person(s) from engaging in his/her occupation.

b. We will stop making payments when we are satisfied that the Insured Person(s) can engage in his/her occupation again, or when we have made payments for a maximum period of 100 weeks from the date the Insured Person(s) met with the Accidental Bodily Injury, whichever is earlier.

5. **Additional Insurance**

a. **Transportation (Available if the schedule shows you opted for it)** If we have accepted a claim under 1) for death of the Insured Person(s), then we will pay towards the actual cost of transportation of the remains of the Insured Person(s) from the place of death to a hospital, Insured's home, cremation ground, burial ground. The amount we will pay will be limited to the lower of Rs 5000/- and 2% of the sum assured shown under the schedule headings Basic, Wider and Comprehensive for the Insured Person(s).

b. **Children's Education Benefit (Available if the schedule shows you opted for it)** If we have accepted a claim under either 1) or 2), then we will make a one-time payment of Rs 5000/- each towards the cost of education of upto 2 of the dependent children of the Insured Person(s) who were under the age of 19 at the date the Insured Person(s) met with Accidental Bodily Injury.

c. **Hospital Confinement Allowance (Available if the schedule shows you opted for it)** If we accepted a claim under 1) to 4), then we will pay Rs 1000/- for each complete calendar day that the Insured Person(s) had to be hospitalised for medical reasons because of the Accidental Bodily Injury he/she met with. However the amount we pay will be limited to Rs 30,000/- during the policy period even if there is more than one claim for the Insured Person(s)

d. **Medical Expenses Reimbursement (Available if the schedule shows you opted for it)** If we have accepted a claim under 1) to 4), then we will reimburse the costs of necessary medical treatment the Insured Person(s) had to obtain from a Doctor because of the Accidental Bodily Injury the Insured Person(s) met with. However our payment will be limited to 40% of the value of the claim we accepted under 1) to 4) or Rs 5, 00,000/-, whichever is lower.

SECTION D) EXCLUSIONS UNDER THE POLICY - STANDARD EXCLUSIONS

What we will not pay for
We will not pay for any event that arises because of, is caused by, or can in anyway be linked to any of the following.

1. Maternity (Excl 18) :
a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SECTION D) EXCLUSIONS UNDER THE POLICY - SPECIFIC EXCLUSIONS

What we will not pay for
We will not pay for any event that arises because of, is caused by, or can in anyway be linked to any of the following.

1. Accidental Bodily Injury that the Insured Person(s) meet with:
a. Through suicide, attempted suicide or self-inflicted injury or illness.
b. While under the influence of liquor or drugs
c. Arising or resulting from the insured person (s) committing any breach of law with criminal intent
d. Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any duly licenses standard type of aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.
e. Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trail runs.
f. As a result of any curative treatments or interventions that the Insured Person(s) carry out or have carried out on his/her body.
g. Arising out of the participation of the Insured Person(s) in any naval, military or air force operations whether in the form of military exercises or war games or actual engagement with the enemy, whether foreign or domestic.
2. The Insured Person(s) 'consequential losses of any kind or their actual or alleged legal liability.
3. Venereal or Sexually transmitted diseases
4. HIV (Human Immunodeficiency Virus) and/or any HIV related illness including. AIDS (Acquired Immune Deficiency Syndrome) and/or mutant derivatives or variations thereof however caused.
5. War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
6. Nuclear energy, radiation.
7. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies.

SECTION E) CONDITIONS - STANDARD GENERAL TERMS AND CLAUSES

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

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

3. Claim Settlement. (provision for Penal interest)
i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

4. Renewal of Policy
i. Your Policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by You, provided this policy is not withdrawn and also subject to conditions stated at "Moratorium Period" of this Schedule.
ii. We shall not deny the renewal of this policy on the ground that You have made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.
iii. We shall condone a delay in renewal up to the Grace Period (30 days) from the due date of renewal without considering such condonation as a Break in Policy.
iv. For this policy, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience.

However, discount in premium may be provided by Us to You for good claims experience.

v. We shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile, We may endeavour to recognize that for removal of loadings at the point of renewal.

vi. In case the product is withdrawn, the policyholder shall be provided with suitable alternative options for migration, as per applicable regulatory provisions.

5. Possibility of Revision of Terms of the Policy Including the Premium Rates:

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

6. Withdrawal of Policy

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

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

7. Free Look Period

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

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

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

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

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

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

8. Cancellation

(A) Cancellation by the Policyholder

The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -

- Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
- Multi-year Policy:
  - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
  - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis

The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

(B) Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

(C) Cancellation by the Company

The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

(D) In case of any delay in refund of premium beyond stipulated 7 days, the Company shall refund such amounts along with interest, at a rate 2% above the bank rate on the refundable amount, from the date of receipt of the request for cancellation till the date of refund.

9. Fraud

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

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

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

a) the suggestion, as a fact of that which is not true and which the Insured beneficiary does not believe to be true;
b) the active concealment of a fact by the Insured beneficiary having knowledge or belief of the fact;
c) any other act fitted to deceive; and

d) any such actor 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 beneficiary / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer

10. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/ she wants to claim the balance amount.

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

11. Moratorium Period:

After completion of sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co- payments, deductibles as per the policy contract.

12. Migration

The Insured beneficiary will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

13. Portability

The Insured beneficiary will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. Insurer is free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.
For Detailed Guidelines on portability, kindly refer the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

14. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

16. Redressal of Grievance

The Company has always been known as a forward-looking customer centric organization. It takes immense pride in it's approach, through "Bajaj General" Application. To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, Say "Hi" on WhatsApp on +91 7507425858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajgeneralinsurance.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajgeneralinsurance.com/about-us/customer-service.html
4. E-mail

a) Level 1: Write to careforyou@bajajgeneral.com and for senior citizens to seniorcitizen@bajajgeneral.com
b) Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajgeneral.com
c) Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back

5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available

at https://www.cioins.co.in/ombudsman. The contact details of the Ombudsman offices are mentioned in, https://www.bajajgeneralinsurance.com/download-documents/health-insurance/OMBUDSMAN-ADDRESS.pdf

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
E-mail: inscoun@cioins.co.in, **Tel**: 022 -69038800/69038812, **Website**: https://www.cioins.co.in

SECTION E) CONDITIONS - SPECIFIC TERMS AND CLAUSES

17. Paying a claim

i. You agree that We need only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

ii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, we shall offer within a period of 15 days a settlement of the claim to you. Upon acceptance of an offer of settlement by you, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by you. In the cases of delay in the payment, we shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

iii. However, where the circumstances of a claim warrant an investigation, the Company will initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company will settle the claim within 15 days from the date of receipt of last necessary document. In case of delay beyond stipulated 15 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim

iv. If we, for any reasons decide to reject the claim under the policy, the reasons regarding the rejection shall be communicated to you in writing within 15 days of the receipt of complete set of documents. You may take recourse to the Grievance Redressal procedure.

18. Territorial Limits

i. We cover Accidental Bodily Injury sustained during the Policy Period anywhere in the world (subject to the travel and other restrictions that the Indian Government may impose), but we will only make payment within India and in Indian Rupees.

ii. For Medical Expenses Section & Hospital Confinement Allowance, we will make Payment for expenses incurred in India & in Indian rupees.

19. Applicable Law

Indian law governs this Policy and the relationship between us. The section headings we have used are for ease of reference rather than for any interpretative purpose.

20. 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 decision of a sole arbitrator in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of the arbitrators comprising of two arbitrators, one 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. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be within India

i. 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.

ii. 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

iii. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

21. Renewal

Under normal circumstances, lifetime renewal benefit is available under the policy except on the grounds of fraud, misrepresentation or moral hazard.

a. In case of our own renewal a grace period of 30 days is permissible and the Policy will be considered as continuous. Any medical expenses incurred as a result of Accident contracted during the break period will not be admissible under the policy.

b. For age 66 years and above, renewal Sum insured would be restricted to lower of Rs10 lacs (under Basic and or Wider) or expiring policy sum insured under Basic and / or Wider sections.

c. However renewals can be considered with higher sum insured subject to Submission of requisite documentation to ascertain commensuration of income.

d. Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA.

22. Insured

Only those persons named as the insured in the Schedule shall be covered under this Policy. Cover under this Policy shall be withdrawn from any insured member upon such insured member giving 14 days written notice to be received by us.

23. Communications

Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.

24. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except us. Any change that we make will be evidenced by a written endorsement signed and stamped by

25. Policy changes

No change can be made to this Policy unless we have approved it, and confirmed our approval by endorsing the schedule. No one is authorized to make or confirm any change on our behalf.

26. Change of Occupation

If you change occupation then you must tell us in writing within 30 days of the change. If you do not do this, then this insurance will cease as far as you are concerned from the date that you changed your occupation. If you meet with Accidental Bodily Injury before you have told us of a change in occupation and your new occupation would have attracted a higher premium, then the payment we make will be limited to the amount of insurance that the premium you have actually paid would have brought for your new occupation.

SECTION E) CONDITIONS - OTHER TERMS AND CONDITIONS

27. Making a Claim

If you meet with any Accidental Bodily Injury that may result in a claim, then as a condition precedent to our liability:

a. You or someone claiming on behalf must inform us in writing immediately and in any event within 30 days.
b. You must immediately consult a Doctor and follow the advice and treatment that he recommends.
c. You must take reasonable steps to lessen the consequence of Bodily injury.
d. You must have yourself examined by our medical advisors if we ask for this.
e. You or someone claiming on behalf must promptly give us documentation and other information we ask for to investigate the claim or our obligation to make payment for it.
f. In case of your death, someone claiming on your behalf must inform us in writing immediately and send us a copy of the post mortem (if performed) report within 30 days.

***Note:** Waiver of conditions (a) and (f) may be considered in extreme cases of hardship where it is proved to our satisfaction that under the circumstances in which you were placed, it was not possible for you or any other person to give notice or file claim within the prescribed time limit.

Claim documents to be submitted for Personal Accident

a) Death Cover

- Duly Completed Personal Accident Claim Form signed by Nominee.
- Copy of address proof (Ration card or electricity bill copy).
- Attested copy of Death Certificate.
- Burial Certificate (wherever applicable).
- Attested copy of Statement of Witness, if any lodged with police authorities.
- Attested copy of FIR / Panchanama/ Inquest Panchanama.
- Attested copy of Post Mortem Report (only if conducted).
- Attested copy of Viscera report if any (Only if Post Mortem is conducted).
- Claim form with NEFT details

b) Permanent Partial /Total Disablement cover:

- Duly Completed Personal Accident Claim Form signed by insured.
- Attested copy of disability certificate from Civil Surgeon of Government
- Hospital stating percentage of disability
- Attested copy of FIR.
- All X-Ray / Investigation reports and films supporting to disablement.
- Claim form with NEFT details

c) Temporary Total Disablement:

- Duly Completed Personal Accident Claim Form signed by insured.
- Medical fitness certificate from treating doctor mentioning the type of disability and period of rest with date of fitness.
- Leave certificate from the employer for disablement period
- Attested copy of FIR
- All X-Ray reports and films
- All medical bills (for medical expenses claim).

d) Children's education bonus

- Bonafide certificate from school / college or certificate from the
- educational institution

e) Hospital confinement Allowance

- Duly Completed Claim Form duly signed by the insured with NEFT details
- Copy of Discharge Summary / Discharge Certificate.
- Copy of Final Hospital Bill

f) Claim documents to be submitted for hospitalisation claim

- First Consultation letter from the Doctor
- Duly completed claim form and NEFT Form signed by the Claimant
- Original Hospital Discharge Card
- Original Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, Transfusions, Room Rent, etc.
- Original Money Receipt, duly signed with a Revenue Stamp
- All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
- Other documents as may be required by Bajaj General to process the claim

***Note: Aaadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim).**

List I: List of Non-Medical Items

SL No	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED	Not Payable
22	Television Charges	Not Payable
23	SURCHA RGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable

36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL NURSING	Not Payable
53	SUGAR FREE Tablets	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER, URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

List II - Items that are to be subsumed into Room Charges

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED /INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CARDLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS

11	TISSUE PAPPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINEFCTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36	PATIENT IDENTIFICATION BAND / NAME TAG

List III- ems that are to be subsumed into Procedure Charges

S. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD ,CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPE AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER

12	SURGICAL BLADES,HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/CAPD EQUIPMENTS
7	INFUSION PUMP-COST
8	HYDROGEN PERPOXIDE\SPIRIT\DISINFECTION ETC
9	NUTTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG