ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

POLICY FOR PROTECTION OF POLICYHOLDER'S INTERESTS

Background

The ability of the insurance industry to achieve its socio-economic objectives depends on the satisfaction levels of its customers. The Company strongly believes that a satisfied customer is the most crucial force that determines success of its business.

Customer Service is a key focus area of the Company. The Company follows a holistic approach for augmenting its quality of service to the customer and targets consistent improvement in customer experience and quality of operations.

The Company strives to handle all customer complaints and issues in a timely manner and without bias. Customer complaints provide valuable insights into the internal processes and procedures of the Company (including automated processes) that have an impact on the Company's ability to conduct business efficiently and successfully. It is with this view that the Policy for Protection of Policyholder's Interests (Policy) has been articulated. The Policy shall be updated from time to time as deemed fit by the Company and shall be in line with the Regulatory requirements as and when prescribed.

The Company shall ensure that all employees are informed about the policy and its subsequent updates.

1. Definitions

a) "Authority" means
   - Insurance Regulatory and Development Authority of India ("IRDAI") for Company and;
   - International Financial Services Centres Authority ("IFSCA") for IIO

b) "Company" means ICICI Lombard General Insurance Company Limited including its IIO, unless specified otherwise.

c) Grievance/Complaint: A Complaint or Grievance means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a complainant with insurer, distribution channels,

intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities;

Explanation: An inquiry or request would not fall within the definition of the "complaint" or "grievance".

d) "IIO" means International Financial Services Centres Insurance Office of the Company registered under the International Financial Services Centres Authority (Registration of Insurance business) Regulations, 2021 and situated at Gift City Gandhinagar, Gujarat.

e) Inquiry: An "Inquiry" is defined as any communication from a customer for the primary purpose of requesting information about a company and/or its services.

f) Regulations" means IRDAI (Protection of Policyholders' Interests Regulations, 2017), as amended from time to time, for the Company and/or International Financial Services Centres Authority (Registration of Insurance business) Regulations, 2021 and guidelines issued thereunder as amended from time to time, for the IIO, as the case may be.

g) Request: A "Request" is defined as any communication from a customer soliciting a service such as a change or modification in the policy.

h) Unclaimed Amounts: "Unclaimed Amount" shall include any amount held by insurers but payable to policyholders or beneficiaries, including interest accrued thereon, remaining unclaimed beyond six months from the due date or settlement date of such amount, whichever is earlier.

Explanation 1 – unclaimed amounts may arise in respect of death claim, health benefit claim, maturity claim, survival benefit, surrenders/ foreclosures, premium due for refund, premium deposit not adjusted against premium and indemnity claims.

Explanation 2 – In case of general and standalone health insurers, any premium received in advance/ deposits/ unallocated premium during the currency of the insurance policy shall not be considered as unclaimed amount. However, where the premium received in advance/ unallocated premium has neither been set off/

adjusted against the premium during the currency of the policy nor has been refunded within six month from expiry of the policy, such amount shall be considered as unclaimed amount.

2. Objectives

The objective of the Policy is to ensure that:

- All customers are treated fairly at all times.
- All complaints, critical requests and issues raised by customers are dealt with courtesy and resolved on time.

- The system and procedures for receiving, registering and disposal of grievances are unambiguously laid down

- The grievance redressal procedure is made available to the customers. Customers are made completely aware of their rights so that they can opt for alternative remedies, if they are not fully satisfied with the response or resolution to their complaint by the Company.

3. Customer Segments

Segmentation of customers is done in the following ways:

- Corporate segment
  - Large Corporate
  - Small and Medium Enterprise (SME)
- Retail segment
- Government segment
- Rural segment

4. Approach Towards Customer Service

a. Customer Approach: Based on the requirements, the strategy that best suits a particular segment shall be adopted. For example, the approach for Rural segment needs to be local in nature, for Corporate segment the approach needs to be relationship based whereas for Retail segment it needs to be multi-channel and centralized. The guiding principles of the approach to customer service in all these segments shall be as follows:

i. **Customer Education:** The Company shall undertake several initiatives for educating and enhancing insurance awareness amongst its customers, prospective customers and the general public at large about the company's products, the benefits derived thereunder; customer's rights in accordance with the Insurance Awareness Policy as adopted by the Company.

ii. **Customer Communication:**

- **Transparency:** The customer shall be provided with information regarding the channels he can access in order to service his requirements and resolve his issues. In addition', the turn-around- time for the redressal of issues and the expectations on investigation and resolution also need to be transparently communicated.

- **Accessibility:** The strategy of the Company is to enable customers to avail of services through multiple channels, which shall provide uniform service delivery. Customers can use Branch Offices including IIO Office, Call Centre, Internet, e-mail and regular post for forwarding their requests, issues or complaints.

- **Escalation:** Customer shall be informed as to how he can escalate his complaint to the next level in case he is not satisfied with the resolution provided by the current level.

iii. **Customer feedback:** Mechanisms to obtain customer feedback on a regular basis and derive actions from such feedback shall be put in place to check the current level of customer service, trends over a period of time and to take appropriate steps towards meeting customer expectations and for enhancing customer service standards for speedy resolution of customer complaints.

iv. **Products Features:** The Company shall also ensure that during policy solicitation and sale stages, the prospects are fully informed and made aware of the benefits of the product being sold vis-à-vis the product features attached thereto and the terms and conditions of the product so that the benefits / returns of the product are not mis-stated / mis-represented.

v. **Publicizing of Grievance Redressal procedure:** The Company shall publicize its grievance procedure, service parameters and turnaround times and ensure that it is specifically made available on its website and at its offices. Any change in the service parameters and turnaround times as approved by the Board of Directors shall be updated on the company website.

b. Internal Approach:

- Service Parameter: Every category of Customer Request and Customer Complaint shall have pre-defined turnaround time (TAT) in compliance with the IRDA Guidelines for Grievance Redressal by Insurance Companies dated July 27, 2010 and forms part of this policy as Annexure-3. The company's policy, service parameters, turnaround times, grievance redressal procedures shall be made available to the customers and will also be uploaded on the Company's website to ensure that customers are made completely aware of their rights so that they can opt for alternative remedies if they are not fully satisfied with the company's response or resolution to their complaint.

i. Resolution: The following shall be defined:

- Quality of resolution: Standards of what constitutes quality resolution and what is considered as a valid closure.

- Responsibility for resolution: The responsibility of resolution at every level starting from the business head.

- Escalation: Escalation mechanism to ensure that the issues, which are not resolved, are put up to the next level. All channels and functions shall put an internal escalation mechanism in place.

  Central as well as local teams within the organization shall be set- up to ensure monitoring of quality of resolution, turn-around time and adherence to the above processes.

ii. Process improvements: The product, service and channel teams shall ensure that the information on customer complaints and issues is utilized to improve processes. A root cause analysis shall be done to ensure that process fixes are put in place so that similar issues do not recur. The Service Quality team, shall circulate reports to the senior management regarding the action taken in this regards.

iii. Employee training and awareness:

- Employees form an important link in the chain of customer interaction. They may be directly dealing with the customers or may be indirectly responsible for certain activities relating to the customer service. Employees who are directly involved with the customers shall be trained on an ongoing basis on products, services and processes of the Company. Necessary steps and training shall be undertaken to build and strengthen the customer service orientation in the Company.

- Requests, Grievance, Complaint and enquiries as defined under the Policy shall be clearly and unambiguously spelt out and understood by the employees to ensure uniformity and standardization in approach.

- Employees shall be trained on the basics of handling and resolving customer issues like capturing complaints in the system deployed for the purpose and informing customers of the resolution time. The Employee resolving customer issues shall be aware of the impact the resolution will have on the customer. Issues or complaints shall be resolved based on the following principles:

    - Prompt response within the stipulated time frame
    - Maximization of customer retention at minimum cost
    - Correction of mistakes and errors quickly
    - Changes in the processes to improve customer satisfaction

iv. **Performance management:** It is essential to emphasize the importance of customer service at all levels, share relevant information and reports and conduct self-audits of service performance. In order to ensure this, adequate weightage shall be given in performance management at all levels including those interacting and interfacing the customer, back offices, and support functions.

v. **Confidentiality of customer information:** The Company shall at all times maintain total confidentiality of Policyholder information so obtained and shall not disclose to anyone not authorized to receive unless such disclosure is required by law and/or is required to be made to any statutory authorities.

5. Operating Structure for Customer Service

a. Board level focus: The Board of Directors of the Company have constituted a Committee namely 'Policyholder Protection Committee'. The Policyholder Protection Committee shall review Customer Service initiatives and deliberate on measures for enhancing the quality of customer service and improvement in overall service levels.

b. Reporting requirements: Based on definitions of requests, critical requests and complaints, data shall be maintained by the respective teams at a central point for reporting to senior authorities of the Company as well as to external regulatory authorities.

c. Grievance Redressal Officer (GRO): The Company has appointed and shall keep appointed a designated "Grievance Redressal Officer" at a Senior

Management Level at its corporate office. The Company shall also designate a Grievance Officer in all its branch offices, including IIO office, to whom a complaint can be raised. The contact details of the GRO shall be published on the website of the Company along with contact details of the Grievance officer of all branch offices and shall also be displayed on the notice board of respective offices.

d. Ombudsman Office: Every branch office of the Company, including IIO office, shall display in a prominent place, the name, address and other contact details of the insurance ombudsman within whose jurisdiction the branch office falls.

6. Grievance Redressal System and procedure

The procedure for effective redressal of Grievances of the customers (complainants) shall be as under:

a. A written acknowledgement to a complainant shall be sent within 3 working days of receipt of grievance.

b. The acknowledgement shall contain name and designation of the employee who will deal with the grievance.

c. The acknowledgement shall also contain the details of the company's grievance redressal procedure and time taken for resolution of disputes.

d. If the grievance is resolved within 3 working days the resolution shall be communicated to the complainant along with the acknowledgement.

e. Where the grievance is not resolved within 3 working days, it shall be resolved within 2 weeks of receipt of the complaint and a final letter of the resolution shall be send to the complainant.

f. A written response on redressal or rejection of the complaint shall be sent within 2 weeks along with the reasons for the same.

g. The complainant shall be informed about how he/she may pursue the complaint, if dissatisfied.

h. It shall be informed to the complainant that the complaint shall be regarded as closed if no response is received by the complainant within 8 weeks from the date of receipt of the complaint.

7. Closure of Grievance

A complaint shall be considered as disposed of and closed when:

a. The request of the complainant is fully acceded.

b. The complainant has indicated in writing acceptance of the response of the insurer.

c. The complainant has not responded within 8 weeks of the company's written response.

d. The Grievance Redressal Officer has certified that the company has discharged its contractual, statutory and regulatory obligations and therefore complaint can be closed.

e. In the event, the grievance is not resolved in favour of the policyholder or partially resolved in favour of the policyholder, the Company shall inform the complainant of the option to take up the matter before insurance ombudsman giving details of the name and address of the Ombudsman of competent jurisdiction.

8. Statutory/Regulatory Compliance

Detailed procedures for handling issues relating to customer service (as specified in section 5 (b) above) shall be laid down separately with the approval of Grievance Officer. These procedures shall take into account the applicable regulatory requirements including the necessity of speedy resolution of customer complaints.

The procedures shall also adhere to statutory guidelines as applicable to customer service.

9. Unclaimed amounts of Policyholders

The company shall take all necessary steps to reduce the unclaimed amounts of policyholders. Any unclaimed amount remaining for a period of over 10 years shall be transferred to the Senior Citizen’s Welfare Fund (SCWF) set up by the Government of India as part of the Finance Act 2015.

Annexure - 3 Servicing TATs

S.No	Description	Mapping of PPI Provisions to classification structure	Servicing TATs
(1) Proposal Related			
1	Insurer collected premium – Issued policy without any proposal or confirmation in writing from Insured	4 (1) Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document. It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.	30 days
2	Insurer accepted premium and then rejected the proposal	3(5) In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by: i) the Authority ii) the Councils that have been established under section 64C of the Act and iii) the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.	10 days
3	Insurer not furnishing proposal copy after acceptance of risk	Refer S.No. 1	30 days
4	Insured does not know the scope of coverage and other terms where Proposal form was filled up by Agent	A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to all the riders put together shall exceed 30% of the premium of the main product. 11 (1) The requirements of disclosure of "material information" regarding a proposal or policy apply, both to the insurer and the insured. (2) The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties. (3) The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy. (4) Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.	10 days
5	Proposal form given by Insured was tampered by Agent / Insurer	Refer S.No. 2	10 days
r Note Related			
6	Cover Note not received	Refer S.No. 2	10 days
7	Scope of cover not explained	A prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance	10 days
licy Related			
8	Certificate of Insurance / Policy not received by the Insured	Refer S.No. 2	10 days
9	Details incomplete in the policy.	**7(1)** A general insurance policy shall clearly state: (a) the name(s) and address(es) of the insured and of any bank(s) or any other person having financial interest in the subject matter of insurance; (b) full description of the property or interest insured; (c) the location or locations of the property or interest insured under the policy and, where appropriate, with respective insured values; (d) period of Insurance; (e) sums insured; (f) perils covered and not covered; (h) any franchise or deductible applicable;	10 days
		(i) Nomination details to be noted	
		(j) Financier's Interest to be shown in policy	
10	Details shown in policy or Add-on are incorrect.	Refer S.No.9	10 days

11	Endorsement for modification of policy/add on not issued by the Insurer	**10 (g)** issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and	10 days
12	Insured asked for cancellation of policy, Insurer failed to respond	**10 (1)** An insurer carrying on life or general business, as the case may be, shall at all times, respond within 10 days of the receipt of any communication from its policyholders in all matters	10 days
13	Insured asked for issue of a duplicate policy – Insurer failed to issue	**10(f)** issuance of duplicate policy;	10 days
14	Nomination details given by Insured not noted in policy.	**10(b)** noting a new nomination or change of nomination under a policy;	10 days
15	Insurer cancelled policy arbitrarily without serving notice	It will be fair to issue notice to Insured, before cancellation of Policy	10 days
16	In the renewal policy, Insurer changed the terms & conditions without informing the Insured	Policy terms, conditions and warranties; should not be changed arbitrarily	10 days
17	Details shown in policy different from the Cover Note.	Refer S.No.17	10 days
18	Insurer refused to accept Insured's request to enhance coverage mid-term.	If this request cannot be accepted, Insurer to write to Insured giving reasons.	10 days
19	While renewing the policy Insurer refused to enhance the Sum Insured sought by	Reasons for refusal to be communicated to Insured	10 days
20	Insurer forced Insured to switch over to a new policy.		10 days
21	Without the consent of Insured Insurer debited customer's bank A/c / credit card and issued policy.	Refer S.No. 2	10 days
22	Insurer refused to renew the policy without giving any reasons.	Refer S.No. 2	10 days
23	Change of address not noted	**R**ecording change of address;	10 days
24	Product no longer available with Insurer		10 days
Premium			
25	Premium receipt not received by Insured	Refer S.No. 2	10 days
26	Insurer calculated premium wrongly and over charged the Insured.	Refer S.No. 2	10 days
27	Insurer loaded premium arbitrarily	Insured to be advised in advance	10 days
28	Premium paid through electronic modes/cheque not accepted	Insurer to make arrangements to accept Premium in all accepted modes	10 days
29	Where provisional premium is collected, final adjustment is not carried out	Where the premium is provisional subject to adjustment, the basis of adjustment of premium be stated;	10 days
30	Premium cheque bounced. Without giving intimation to Insured Insurer. cancelled the policy		10 days
Coverage			10 days
31	Insurer did not attach any clauses to the policy – coverage given under the policy	A general insurance policy shall clearly state: perils covered and not covered;	10 days
32	Dispute relating to Interpretation of perils/exclusions/conditions/warranties	Refer S.No. 2	10 days
33	Dispute relating to policy extension of term for Long term policies	Refer S.No. 2	
34	Wrong add on policy wording	Refer S.No. 2	
) Refund			
35	Refund of premium due under policy not received by Insured.	Insurer to make refund of premium on their own	10 days
36	Dispute regarding quantum of premium refund.	Insurer to convey to Insured as to how they arrived at the quantum of refund	10 days
Product			
37	Product (policy) received by insured is not what it was negotiated at the time of sale.	Refer S.No. 2	10 days
38	Misleading Advertisement issued by Insurer. Product was different from what it was advertised.	Refer S.No. 2	10 days
8) Claim			

39	Insurer refusing to register claim	An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 72 hours of the receipt of intimation from the insured.	10 days
40	Insurer asking for irrelevant claim documents	Refer S.no. 39	
41	Insurer asking for claim documents on a piecemeal basis.	Refer S.no. 39	
42	Delay in appointment of surveyor	Refer S.no. 39	72 hours
43	Insurer not issued claim form.	Refer S.no. 39	10 days
44	Delay in conducing survey.	Insurer should advise the Surveyor to stick to the time -frame	10 days
45	Surveyor delayed issue of his report.	Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where, in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report.	30 days
46	Survey report copy not issued to the Insured by the surveyor.	Refer S.No. 45	30 days
47	Difference between assessed loss and amount settled by Insurer.	Insurer should explain to the Insured the reasons	10 days
48	Insurer reduced the Quantum of claim for reasons not indicated in the policy.	Refer S.No. 47	
49	Insurer failed to make offer of settlement to Insured after receipt of survey report.	On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be.	30 days
50	Insurer not disposed of the claim	Without valid reasons, Insurer should not keep any Claim beyond the time frame	30 days
51	Insurer not issued claim cheque inspite of offer of settlement.	Upon acceptance of an offer of settlement as stated in sub-regulation (5) by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer 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.	7 days
52	Cheque issued by Insurer is bounced.	Insurer should send fresh cheque /draft, the moment they come to know about the bouncing of the cheque	10 days
53	Name of Insured wrongly written in the claim cheque.	Insurer should doubly make sure not allow such errors	10 days
54	Insurer closed the claim without advising the Insured any reasons.	Refer S.No. 47	10 days
55	Dispute between Insured and Insurer on (a)Rate of depreciation applied, (b) amount allowed towards Labour charges (Motor claim), (c) deduction of salvage value, (d) obsolete factor.	Insurer should write to the Insured and resolve the disputes	10 days
56	Dispute on mode of claim settlement – Total loss / cash loss vis-à-vis repair basis.		30 days
57	Claim denied due to alleged non-cooperation of Insured		30 days
58	Insurer repudiated claim due to delay in intimation of claim by Insured.	It would be proper to ascertain the reasons for delayed intimation and consider admission of claim on merits	10 days

59	Insurer repudiated claim due to delay in submission of claim documents by the Insured.	Without giving notice in advance calling for required documents, Insurer not repudiate a claim	10 days
60	Insurer repudiated the claim based on 2nd surveyor's recommendation.	Insurer should give reasons in the letter of repudiation	10 days
61	Insurer repudiated the claim due to alleged breach of policy condition / warranty.	Refer S.No. 55	10 days
62	Insurer repudiated claim due to dispute on premium paid.	Refer S.No. 55	10 days
63	Insurer repudiated claim due to alleged fraud.		10 days
64	Claim repudiated without giving reasons	Refer S.No. 59	10 days
65	Insurer repudiated claim due to "pre-existing disease exclusion" (Health Insurance).		10 days
66	Claim repudiation by Insurer due to bouncing of premium cheque presented late by Insurer.		10 days
67	Insurer repudiated claim due to alleged carelessness of Insured.		10 days
68	Delay on the part of TPA to arrange claim reimbursement (Health claim).		30 days
69	TPA reduces estimate given by the hospital without any reason.		10 days
70	Delay on the part of TPA to provide cashless facility.		10 days
71	TPA refuses to extend cashless facility to the Insured.		10 days
(9) Distance marketing			
72	Insurer calls for solicitation of business inspite of client registering in DNC		10 days
73	Insurer making repeated and unsolicited calls		10 days
74	Mis-selling on distant calling		10 days
75	Explaining excessive features of a policy to a prospect on calls		10 days
76	Insurer debiting premium on cards arbitrarily		10 days
77	Insurer not refunding amount debited arbitrarily on Credit cards		10 days
(10) Others			
78	IDV related disputes		10 days
79	Higher/wrong deductible imposed by Insurer		10 days
80	Insurer imposed additional conditions wrongly.		10 days
81	TPA not sent ID card to Insured (Health claim).		10 days
82	Insurer not considered the cumulative bonus in claim settlement (PA or Health claim).	Cumulative bonus relevant to PA or Health policy should be allowed	10 days
83	Insurer not given no claim bonus (Motor Insurance)	Insurer should allow No Claim Bonus as per entitlement	10 days
84	Insurer gave premium quote but later went back on acceptance of risk.	The quote should indicate the validity period	10 days
85	Insurer failed to clarify the queries raised by Insured.	Refer S.No. 12	10 days
86	TPA not sending pre-authorization to the Hospital (denial of cashless facility).		10 days
87	Insurer not given eligible discount in premium (Family Discount on Health / PA policy/package policy)	Refer S.No. 12	10 days
88	Misbehavior of surveyor towards the Insured.		10 days
89	Insurer not taken any loss prevention measures upon reporting of a claim by Insured.		10 days

90	Failure of online transaction though premium was deducted through credit card.		10 days
91	Rebating resorted to by Agent.		10 days
92	Rebating resorted to by Insurer.		10 days
93	Fraudulent behavior on the part of Agent in claim matter		10 days
94	Errors in ID cards issued by TPAs.		10 days
95	Alleged misconduct of officials of TPA towards the Insured.		10 days
96	No response from TPA / Insurer for queries raised / clarifications sought by Insured.		10 days
97	IT /Network related / connectivity issue with TPA.		10 days
98	TPA delayed Health check-up.		10 days
99	TPA delayed issue of reports of Health check-up.		10 days
100	Alleged misconduct of officials of Insurer.		10 days
101	Alleged misconduct of surveyor / investigator.		10 days
102	Unsolicited calls made to Insured in spite of DNC registration.		10 days
103	Complaint of Insured relating to pre-inspection / pre-acceptance survey.		10 days
104	Cashless facility first sanctioned and withdrawn.		10 days
105	Where claim is repudiated, Bills / reports not returned to the customer.		10 days
106	Non-acceptance of health cards by network hospital.		10 days
107	Unable to register Grievance due to faulty systems		10 days