**ManipalCigna Health Insurance Company Limited** (Formerly known as CignaTTK Health Insurance Company Limited)
**OR** Nearest ManipalCigna Branch.
**Registered & Corporate Office**: 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063.
IRDAI Registration No. 151. **Call** (Toll Free): 1800-102-4462 **Visit:** www.manipalcigna.com **E-mail:** servicesupport@manipalcigna.com
**CIN:** U66000MH2012PLC227948
The issue of this Form is not to be taken as an admission of liability
(To be filled in Block Letters) - PART A - To be filled by Insured

ManipalCigna Health Insurance

## 5 easy ways to speed up the claims process

1. Submit all original documents as per the checklist within 15 days of discharge from the hospital.
2. Make sure the form is complete and don't forget to sign.
3. Provide correct and accurate bank details with Cancelled cheque
4. For any assistance, please reach out to your health advisor or connect with our Health Relationship Manager.
5. Do not conceal or withhold any information with respect to your claim.

# MANIPALCIGNA PROHEALTH GROUP INSURANCE POLICY CLAIM FORM A

**SECTION I- TO BE COMPLETED BY INSURED PERSON/ CLAIMANT**

## A. DETAILS OF POLICY HOLDER:

a. Name of Corporate/ Group:

b. Master Policy Number: c. Certificate of Insurance Number:

d. Company/ TPA ID No:

e. Name of Policy Holder: FIRST NAME MIDDLE NAME LASTNAME

f. Address:

City: State: Pin Code:

g. Date of Birth: DD MM YYYY Age: Years Gender: Male Female

h. Occupation:

i. Telephone Number: j. Phone No:

k. Email ID:

## B: DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No

b) Date of Commencement of First Insurance without Break: DD MM YYYY

c) If yes, Company Name:

Policy No.: Sum Insured (₹):

d) Have you been hospitalised in the last four years since inception of the contract? Yes No Date: DD MM YYYY

Diagnosis:

e) Previously covered by any other Mediclaim / Health Insurance : Yes No

f) If yes, Company Name:

## C. DETAILS OF THE INSURED IN RESPECT OF WHOM CLAIM IS MADE (IF OTHER THAN POLICY HOLDER)

a. Name of Insured Person:

b. Member ID of the Insured Person:

c. Date of Birth: DD MM YYYY d. Occupation: e. Gender: Male Female

f. Telephone Number: g. Phone No:

h. Email ID:

I. Relationship with Policy Holder:

j. Address, if different from above:

## D: DETAILS OF HOSPITALIZATION / EVENT:

a) Name and Address of the Hospital:

City: State: Pin Code:

b) Room Category Occupied: Ward Shared room Single Private room Deluxe Suite

Any Other

c) Hospitalisation due to: Injury Illness Maternity

d) Date of Injury / Date Disease first detected / Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y Y Y f) Time: H H : M M

g) Date of Discharge: D D M M Y Y Y Y h) Time: H H : M M

i) If Injury, give Cause: Self Inflicted Road Traffic Accident Substance Abuse Alcohol Consumption

Any Other

a. If Medico Legal: Yes No b. Reported to Police: Yes No c. MLC Report & Police FIR attached: Yes No

j) System of Medicine (Allopathic/ AYUSH):

## E. DETAILS OF BENEFITS CLAIMED: (TO BE FILLED BY CLAIMANT AS APPLICABLE)

| a. Benefit | Amount (Rs.) |
|---|---|
| | |
| Others: Code | |
| Total claimed Amount | |
| Pre-hospitalisation Period: Days | |
| Post-hospitalisation Period: Days | |

**Check List of Enclosures for Submission of Claim* (as applicable)**

- Original copy of consultations
- Hospital discharge summary in original
- Hospital main bill in original
- Investigation reports, originals of X Ray, MRI, CT films, HPE, ECG
- Pharmacy bills, prescription and invoices
- KYC documents (photo ID proof, address proof, recent passport size photograph)
- Payment receipt.
- Bills from registered service provider ( Road Ambulance cover)
- Disability certificate, Fitness certificate, Rest certificate
- Copy of claim intimation, if any
- Claim form duly signed
- Operation Theatre Notes (if applicable)
- Hospital break up bill
- Medical Practitioner's reference slip for investigation
- MLC/ FIR report, post mortem report if applicable and conducted
- Cancelled cheque with name for NEFT payment
- Death summary, death certificate, legal heir certificate if applicable
- Income or salary certificate, ITR
- Other insurer details and claims settlement letter if applicable
- Any additional documents available and related to the case**

** Note that We can call for any additional documents from You pertaining to the claim which can be of support in claim assessment.
*Please refer annexure for additional documents required for claim under any Optional benefits (as applicable).

## F. DETAILS OF BILLS ENCLOSED:

| Sl. No. | Bill No. | Date | Issued By | Towards | Nos. | Amount (₹) |
|---|---|---|---|---|---|---|
| 1. | | D D M M Y Y Y Y | | | | |
| 2. | | D D M M Y Y Y Y | | | | |
| 3. | | D D M M Y Y Y Y | | | | |
| 4. | | D D M M Y Y Y Y | | | | |
| 5. | | D D M M Y Y Y Y | | | | |
| 6. | | D D M M Y Y Y Y | | | | |
| 7. | | D D M M Y Y Y Y | | | | |
| 8. | | D D M M Y Y Y Y | | | | |
| 9. | | D D M M Y Y Y Y | | | | |
| 10. | | D D M M Y Y Y Y | | | | |
| | | | | **Total Claimed Amount** | | |

## G. PLEASE SUBMIT THE FOLLOWING DOCUMENTS IN CASE CLAIM AMOUNT EXCEEDS RS. 100,000 (AS PER KYC NORMS):

a. Recent passport size photograph (less than six months old).

b. Proof of Identity (Any one of the mentioned documents).
Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter issued by Unique Identification authority of India containing details of name, address and Aadhar number/ Letter from a recognized public authority verifying the identity of the customer.

c. Proof of Residence (Any one of the mentioned documents)
Telephone bill/ Attested current statement of Bank account details/ Letter from any recognized public authority/ Electricity bill provided it is not older than six months from the date of insurance contract / Ration card/ Passport

## H. DETAILS OF POLICY HOLDER'S BANK ACCOUNT:

Please furnish the details below along with copy of cancelled cheque.

a) PAN: b) Account Number:

c) Bank Name:

d) Branch Name:

e) IFSC Code: f) MICR Code:

g) Cheque / DD Payable Details:

Please attach copy of a cancelled blank cheque of your bank for ensuring accuracy of name of the Bank, Branch name, Account number and IFSC code. If name of the policyholder is not printed on the cheque leaf please attach copy of the first page of the bank passbook also.

## I: DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/ Insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: D D M M Y Y Y Y Place: Signature of the Insured:

## SECTION II: TO BE FILLED BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):

Name of Nominee:

Address:

City: State: Pin Code:

Date of Birth: D D M M Y Y Y Y

Relationship with the Deceased:

Telephone Number: Phone Number:

Email ID:

**DECLARATION BY NOMINEE (IN THE EVENT OF POLICY HOLDER'S DEATH):**

I/We hereby declare that the foregoing particulars are true & correct to the best of my knowledge and belief. I also authorize Insurance Company to make payment of the claim admissible as per terms, conditions and limitations to the Insured person or his legal heir as full and final settlement. I/We will keep indemnified and hold ManipalCigna Health Insurance Co. harmless from any claim under this policy by any third party.

Date: D D M M Y Y Y Y Place: Signature:

## SECTION III: TO BE FILLED BY TREATING DOCTOR WHO ATTENDED THE INSURED

Name of the Insured ('Patient'):

Date of Birth: D D M M Y Y Y Y Age: Years

1. Are you the patient's usual medical attendant? **Yes** **No**

   a. If Yes, since when? D D M M Y Y Y Y

   b. If you have treated him/her for any previous illness or injury, please give details: _____

2. Details of the consultation by the Patient for present illness/ injury.

   a. Date of first consultation: D D M M Y Y Y Y

   b. Presenting Complaints: _____

   c. Nature of Illness/ Injury: _____

   d. History reported: _____

   e. Extent of Illness/ Injury: _____

   f. Diagnosis: _____

   g. Treatment given: _____

   h. If hospitalized:

   Date of Admission: D D M M Y Y Y Y Time of Admission:

   Date of Discharge: D D M M Y Y Y Y Time of Discharge:

3. Has the patient sustained a similar Illness/ injury previously or aggravated a pre-existing condition? **Yes** **No**

   If Yes, please give details: _____

4. If injury, Cause of Present Injury

   Self-Inflicted Road Traffic Accident Substance Abuse/ Alcohol abuse Other:

   Please provide details of cause of injury: _____

5. Is the cause traceable to any disease, previous injuries: **Yes** **No**

   If Yes, please give details: _____

6. Are Injuries sustained in this accident the sole cause of disablement: **Yes** ☐ **No** ☐

7. If injury, please specify the number of days when the injured person is advised rest/unfit and should be confined to bed/house as the direct and sole consequence of the injury sustained

   From: D D M M Y Y Y Y To: D D M M Y Y Y Y

   a. Will the Injured person be able to attend to his/her normal duties? **Yes** ☐ **No** ☐

   b. If Yes, from what date: D D M M Y Y Y Y

8. Has the accident/ illness resulted into loss of hands/ feet/ eye/s or permanent disability of any other type which may prevent Insured from engaging in or being occupied with or giving attention to any employment or occupation whatsoever?

   **Yes** ☐ **No** ☐

   If Yes, please give details: _____

   _____

9. Is the person suffering from any disease or illness apart from his injury which may tend to retard recovery?

   **Yes** ☐ **No** ☐

   If Yes: Give particulars: _____

10. If injury, was he/she under the influence of alcohol/intoxicants or drugs at the time of accident? **Yes** ☐ **No** ☐

11. Nature of disablement:

   a. Permanent Total Disablement **Yes** ☐ **No** ☐

   b. Permanent Partial Disablement **Yes** ☐ **No** ☐

   c. Please specify percentage: _____%

12. Has the present illness resulted in permanent neurological deficit: **Yes** ☐ **No** ☐

   If Yes, please provide duration: _____ months

13. Will the present illness require any major organ/ bone marrow transplant: **Yes** ☐ **No** ☐

   If Yes, please provide details: _____

   _____

14. Has the present illness resulted in loss of speech/loss of hearing/loss of sight: **Yes** ☐ **No** ☐

   If Yes, please provide details with duration: _____

   Is this loss irreversible: **Yes** ☐ **No** ☐

15. In case of injury due to major burns:

   a. Nature and Extent of Burns Injury: _____

   b. Percentage of surface area of Burns: _____

16. Has the present condition resulted in inability to perform following daily activities:

   Washing: **Yes** ☐ **No** ☐ Dressing: **Yes** ☐ **No** ☐

   Transferring: **Yes** ☐ **No** ☐ Toileting: **Yes** ☐ **No** ☐

   Feeding: **Yes** ☐ **No** ☐ Mobility: **Yes** ☐ **No** ☐

17. Has the present illness resulted in deterioration of intellectual/ social functioning and require continuous supervision of the insured person:

   **Yes** ☐ **No** ☐

18. Has the present illness resulted in deterioration of intellectual/ social functioning and require continuous supervision of the insured person:

   **Yes** ☐ **No** ☐

19. In case of Coma:

   Please specify the cause and severity of coma: _____

   Are life support measures necessary to sustain life? **Yes** ☐ **No** ☐

   Extent of neurological deficit: _____

20. Was the history provided by the Insured ('Patient')/ others? **Yes** ☐ **No** ☐

If 'others' please furnish details below: _____

a. Name and relation with the Insured: _____

21. Has the patient been referred to any other Doctor for current / associated ailment? **Yes** ☐ **No** ☐

If so, please furnish details below:

a. Name and address of the doctor / hospital: _____

_____

I hereby state that I have treated the Patient in connection with the above condition and that the facts as given above are correct to the best of my knowledge.

Name of the Doctor:

Registration Number:

Qualification:

Specialization:

Address:

City: State: Pin Code:

Contact Number:

Date: D D M M Y Y Y Y Place: Seal and Signature:

## SECTION IV: TO BE FILLED BY EMPLOYER/GROUP POLICYHOLDER

1. Name of the Company/ Group Policyholder:
2. Address & Contact Details of the Company:
3. Name of the Employee:
4. Date of Joining Service: D D M M Y Y Y Y 5. Designation:
6. Please provide details of the leave availed by the employee, specifying the type of leave.

| Sr. No. | Date from which leave is taken | Date when resumed duties | No. of Days | Type of Leave | In case of Sickness Leave, medical certificate produced- Yes/ No | Reason for Leave |
|---|---|---|---|---|---|---|
| | D D M M Y Y Y Y | D D M M Y Y Y Y | | | | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | | | | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | | | | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | | | | |
| | D D M M Y Y Y Y | D D M M Y Y Y Y | | | | |

Signature and Seal of the authorized signatory of the Company:

Name of the Authorised Signatory:

Designation:

Date: D D M M Y Y Y Y

Place:

## GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured/claimant):

| DATA ELEMENT | DESCRIPTION | FORMAT |
|---|---|---|
| **SECTION I- TO BE COMPLETED BY THE INSURED PERSON** | | |
| **A. Details of Policy Holder:** | | |
| a. Name of Corporate | Enter the company name | Free Text |
| b. Master Policy Number | Enter the policy number | As allotted by the insurance company |
| c. Certificate of Insurance Number | Enter the policy number | As allotted by the insurance company |
| d. Company/ TPA ID No. | Enter the social Insurance number or the certificate number of social health insurance scheme | As allotted by the oraganization |
| e. Name of Policy Holder | Enter the Full Name of the Policy Holder | First Name, Middle Name, Surname |
| f. Address | Enter the Full Postal Address | Include Street, City, State and Pin Code |
| g. Date of Birth (DD/MM/YYYY), Age, Gender | Enter Date of Birth of Policyholder, Age and gender | Use DD/MM/YYYY format for Date of Birth and mention years for Age |
| h. Occupation | Indicate Occupation of Policy Holder | Please specify the Occupation |
| i. Telephone Number | Enter the Phone Number of Policyholder | Include STD code with telephone number |
| j. Phone No | Enter the Phone Number of Policyholder | Please enter a 10 digit number |
| k. Email ID | Enter E-mail Address of Policyholder | Complete E-mail Address |
| **B. Details of Insurance History** | | |
| Currently covered by any other Mediclaim / Health Insurance? | Indicate whether currently covered by another Mediclaim / Health Insurance | Tick Yes or No |
| Date of commencement of first Insurance without break | Enter the date of commencement of first Insurance | Use DD/MM/YYYY format |
| Company Name | Enter the full name of the Insurance Company | Name of the organization in full |
| Policy No | Enter the policy number | As allotted by the Insurance Company |
| Sum insured | Enter the total sum insured as per the policy | In rupees |
| Have you been Hospitalized in the last four years since Inception of the contract? | Indicate whether hospitalized in the last four years | Tick Yes or No |
| Date | Enter the date of Hospitalization | Use DD/MM/YYYY format |
| Diagnosis | Enter the diagnosis details | Open Text |
| Previously covered by any other Mediclaim / Health Insurance | Indicate whether previously covered by another mediclaim / Health Insurance | Tick Yes or No |
| Company Name | Enter the full name of the Insurance Company | Name of the organization in full |
| **C. Details of the Insured in respect of whom claim is made** | | |
| a. Name of Insured Person | Enter the Full Name of the Insured | First Name, Middle Name, Surname |
| b. Member ID of the Insured Person | Enter the member ID number | As allotted by the Insurance Company |
| c. Date of Birth (DD/MM/YYYY) | Enter Date of Birth of Insured | Use DD/MM/YYYY format |
| d. Occupation | Indicate Occupation of Insured | Please specify the Occupation. |
| e. Gender | Indicate Gender of Insured | Tick Male or Female |
| f. Telephone Number | Enter the Phone Number of Insured | Include STD code with telephone number |
| g. Phone No | Enter the Phone Number of Insured | Please enter a 10 digit number |
| h. Email ID | Enter E-mail Address of Insured | Complete E-mail Address |
| i. Relationship with Policy Holder | Indicate Relationship of Insured with Policyholder | Please specify the relationship |
| j. Address if different from above | Enter the Full Postal Address of insured | Include Street, City, State and Pin Code |
| **D. Details of the Insured in respect of whom claim is made** | | |
| a. Name and Address of the Hospital | Indicate the Full Name and Postal Address | Indicate the Full Name of Hospital<br>Include Street, City, State and Pin Code |
| b. Hospitalisation due to (Illness/ Injury/ Maternity) | Indicate reason of hospitalisation | Tick the right option |
| c. Room category occupied | Indicate the room category occupied | Tick the right option |
| d. Date (DD/MM/YYYY) and Time of Injury/ Date of disease first detected/ Date of delivery | Enter the Date and Time of Injury/Death as the case may be | Use DD/MM/YYYY format<br>Use HH:MM format |
| e. Date/ Time of Admission | Enter the Date and Time of Admission | Use DD/MM/YYYY format<br>Use HH:MM format |
| f. Date/ Time of Discharge | Enter the Date and Time of Discharge | Use DD/MM/YYYY format<br>Use HH:MM format |
| g. If injury, give cause | Indicate cause of injury | Tick the right option |

| | | |
|---|---|---|
| If Medico legal | Indicate whether injury is medico legal | Tick Yes or No |
| Reported to Police | Indicate whether police report was filed | Tick Yes or No |
| MLC Report & Police FIR attached | Indicate whether MLC report and Police FIR attached | Tick Yes or No |
| **E. Details of benefits Claimed** | | |
| a. Benefit | Name of the cover for which claim is being made | Enter the full name as mentioned in Policy Schedule/Certificate of Insurance |
| b. Amount | Amount which is being claimed | Enter the amount which is being claimed |
| c. Checklist of enclosures for submission of claim | Indicate which supporting documents are submitted | Tick the right option |
| **F. Details of Bills enclosed** | | |
| Indicate which bills are enclosed with the amount in rupees | | |
| **G. Documents Enclosed** | | |
| a. Recent passport size photograph | Passport size photograph | Provide less than six months old passport size photograph |
| b. Proof of identity | Identity proof is to be submitted | Provide identity proof from a list of mentioned documents |
| c. Proof of residence | Proof of residence is to be submitted | Proof of residence from a list of mentioned documents |
| **H. Details of Primary Insured's Bank account** | | |
| PAN | Enter the permanent account number | As allotted by the Income Tax Department |
| Bank Name | Enter the Bank name | Name of the Bank in full |
| Bank Branch | Enter the Bank branch name | Name of the Bank branch in full |
| Bank Account Number | Enter the Bank account number | As allotted by the Bank |
| IFSC Code | Enter the IFSC code of the Bank branch | IFSC code of the Bank branch in full |
| MICR Code | Enter the MICR Code | MICR Code of the Bank Branch in full |
| Cheque/ DD Payable details | Enter the name of the beneficiary the cheque / DD should be made out to | Name of the individual / organization in full |
| **I. Declaration by the Insured** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |

## ANNEXURE:

| Options | Additional documents required |
|---|---|
| **Critical Illness - Indemnity Cover** | • Medical certificate confirming the diagnosis of Critical Illness<br>• Discharge certificate/ card from the Hospital, if any.<br>• Investigation test reports confirming the diagnosis.<br>• First consultation letter and subsequent prescriptions.<br>• Indoor case papers, if applicable.<br>• Specific documents listed under the respective Critical Illness.<br>• Any other documents as may be required by Us.<br>• In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted. |
| **Critical Illness - Benefit Cover** | • Medical certificate confirming the diagnosis of Critical Illness.<br>• Discharge certificate/ card from the Hospital, if any.<br>• Investigation test reports confirming the diagnosis.<br>• First consultation letter and subsequent prescriptions.<br>• Indoor case papers, if applicable.<br>• Specific documents listed under the respective Critical Illness.<br>• Any other documents as may be required by Us.<br>• In those cases where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted. |
| **Accidental Death Benefit** | • Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station.<br>• Copy of medico legal certificate (if conducted) duly attested by the concerned Hospital.<br>• Original death certificate issued by the office of Registrar of Birth & Deaths.<br>• Copy of post mortem report, if conducted.<br>• Copy of chemical analysis / forensic report, if applicable.<br>• Death summary, if death in Hospital.<br>• Copies of medical records, investigation reports, if admitted to Hospital.<br>• Identity proof of Nominee or original succession certificate/original legal heir certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased Insured Person.<br>• Any other document as may be deemed necessary by Us to evaluate the claim. |
| **PTD/PPD Cover** | • Copy of FIR/ Panchnama /police inquest report (if conducted) duly attested by the concerned police station.<br>• Copy of medico legal certificate(if conducted) duly attested by the concerned Hospital.<br>• Disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board (or) certificate from the treating Medical Practitioner certifying the extent of disability.<br>• Original treating Medical Practitioner's certificate describing the disablement.<br>• Original discharge summary from the Hospital.<br>• Photograph of the Insured Person reflecting the disablement;.<br>• Copies of medical records, investigation reports, if admitted to Hospital.<br>• Any other document as may be deemed necessary by Us to evaluate the claim. |
| **Accumulate Cover** | • Claim form along with the invoices,<br>• Treating Medical Practitioner's prescription, reports, duly signed by the Insured Person |
| **Out- Patient Cover** | • Invoices,<br>• Treating Medical Practitioner's prescription,<br>• Reports,<br>• Duly signed by Insured Person |
| **Dental Expenses Cover & Vision Expenses Cover** | • Claim form<br>• Invoices,<br>• Treating Medical Practitioner's prescription,<br>• Reports, duly signed by the Insured Person as the case may be<br>• For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable:<br>• A full description of the proposed Treatment;<br>• X-rays and study models;<br>• An estimate of the cost of the Treatment. |

| | |
|---|---|
| **Refractive Error Correction Beyond +/- 5 Expenses Cover** | • Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment. |
| **OPD Physiotherapy Charges Cover** | • Bills supported by prescription from registered Medical Practitioner specifying the physiotherapy Treatment taken as an Out-Patient in the Hospital. |
| **Worldwide Emergency Cover** | • In an unlikely event of the Insured Person requiring Emergency medical Treatment outside India, the Insured Person must notify Us either at Our call centre or in writing within 48 hours of such admission.<br>• The Insured Person shall file a claim for reimbursement in accordance with the Policy Terms and Conditions. |
| **Road Ambulance Cover** | • Bills from registered service provider. |
| **Domiciliary Hospitalisation Cover** | • The Insured Person should submit the claim documents at his/her own expense within 15 days of completion of Treatment for eligible period of cover. |
| **Pre-hospitalisation Medical Expenses Cover and Post- hospitalisation Medical Expenses Cover** | • The Insured Person should submit the Post-hospitalisation Medical Expenses Cover claim documents at his/her own expense within 15 days of completion of post-hospitalisation Treatment or eligible post-hospitalisation period of cover, whichever is earlier.<br>• We shall receive Pre-hospitalisation Medical Expenses Cover claim and Post- hospitalisation Medical Expenses Cover claim documents either along with the In-patient Hospitalisation papers or separately and process the same based on merit of the claim subject to Policy terms and conditions, derived on the basis of documents received. This Benefit shall be honoured and the claim can be taken up for processing only after settlement of main hospitalisation claim. |
| **Routine Immunisations Cover** | • Immunisation or vaccination chart,<br>• Medical Practitioner's prescription and supporting pharmacy bills. |
| **Home Nursing Charges Cover** | • Bills from registered nursing service provider. |
| **Health Check Up Benefit** | • The Insured Person shall seek an appointment by calling Our call centre.<br>• We will facilitate the Insured Person's appointment and will guide him/her to the nearest Network Provider for conducting the medical examination. Reports of the medical tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement. |
| **Expert Opinion On Critical Illness Cover** | (a) Receive request for Expert Opinion on Critical Illness<br>• The Insured Person can submit a request for an expert opinion by calling Our call centre or register his/her request through email.<br>(b) Facilitating the process<br>• We will schedule an appointment or facilitate delivery of medical records of the Insured Person to a Medical Practitioner. The expert opinion is available only in the event of the Insured Person being diagnosed with a covered Critical Illness. |
| **Compassionate Cover for family member in case of Emergency or Accident** | • Certificate of Medical Practitioner recommending personal attendance of an immediate family member.<br>• Railway travel ticket/ Air flight boarding pass |
| **Air Ambulance Cover** | • Air ambulance ticket for registered service provider. |
| **Emergency Evacuation Cover** | • In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing.<br>• Emergency medical evacuations shall be pre-authorised by Us.<br>• Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved. |
| **Medical Equipment Cover** | • Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred |
| **Bariatric Surgery Cover** | • Certificate by qualified medical surgeons indicating the medical necessity of the procedure. |
| **Birth Control Procedure Cover** | • All medical records and treating Medical Practitioner's certificate on the indication. |
| **Infertility Treatment Cover** | • Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure. |
| **Deductible (Corporate/Aggregate/ Per Claim)** | • Any claim towards Hospitalisation during the Policy Year must be submitted to Us for assessment in accordance with the claim process laid down under the Policy Terms and Conditions towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with the Policy Terms and Conditions.<br>• Wherever such Hospitalisation claims as stated under the Policy Terms and Conditions is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be. |