1. OBJECTIVE:

The objective of this Group Medical Insurance Policy is to provide assistance to all employees and their families in the unfortunate & unforeseen event of illness, disease or injury.

2. ELIGIBILITY:

The following shall be covered under the Group Medical Insurance Policy:

a) All employees of **IWL/IGESL/RESCO** including the employees on probation shall be covered under the Policy and their spouse and two dependent children. Coverage criteria of Dependent Children:

i) Dependent Children (i.e. legitimate or legally adopted children) up to the age of 21 years.

ii) Female child can be covered until she is unmarried.

iii) Male child can be covered up to the age of 26 years if he is a bonafide regular student and fully dependent on primary insured.

iv) If the child above 18 years is employed or if the girl child is married, he or she shall cease to be covered under the policy and no claim shall be admissible.

b) The Consultants, Retainers and any other category of employee on a fixed term contract shall not be eligible to be covered under the Policy.

c) All resigned and absconding employee shall not be covered under the policy.

3. COVERAGE:

The following medical expenses shall be covered under the Group Medical Insurance Policy:

a. Nursing expenses

b. Room rent

c. Surgeon, anaesthetist, consultant's fee

d. Anaesthesia, diagnostic, OT, blood, oxygen, medicines, radiotherapy, chemotherapy charges.

e. Pre – Hospitalization -Medical Expenses incurred for 30 days prior to hospitalization.

f. Post – Hospitalization- Medical Expenses incurred for 60 days after hospitalization.

g. Maternity Cover under which maternity expenses for any female member shall be covered up to Rs. 25,000/- for normal and Rs.40,000/- for caesarean delivery from day 1. This benefit shall be allowed for only first two children and those insured persons who are already having two or more living children shall not be eligible. Pre & Post natal expenses shall not be covered.

h. Policy shall cover in-patient hospitalisation expenses, provided stay is for minimum period of 24 hrs.

i. However this time limit shall not be applied to specific treatments like Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Lithotripsy (kidney stone removal), and Tonsillectomy etc.

j. It shall also be waived in cases where technology advances lead to hospitalisation for less than 24 hrs.

4. MAIN FEATURES:

The main features of this policy are as below:

a. All pre-existing diseases shall be covered under this policy.

b. Policy shall be applicable in hospitals/nursing homes with min. 15 beds which are registered with Govt. authorities & should have 24 hrs operation theatre & nursing care unit. List of hospitals shall be given to all with the mediclaim cards. (You may also kindly contact the Location HR for the list of hospitals)

c. Room Rent shall be applicable as per below**:**

d. For Sum insured 1-3 lac - 1.5% of the Sum Insured

e. In case of I.C.U. - 2.5% of the sum insured

f. For Sum insured 4-5 lacs - 1.25% of the sum insured

g. In case of I.C.U. - 2% of the Sum Insured

h. The extension wherein any medical expenses incurred during the first 30 days of inception of the policy shall be covered under this Policy.

i. The extension wherein few diseases not covered under normal circumstances during first year of the inception of the policy shall be covered under this Policy.
j. Ambulance Charges shall be payable up to Rs.1000/- in case of emergency.
k.The cashless facility shall be available only for hospitals which are notified by TPA in respective cities/State.
l. The company shall pay 100% of the premium payable to the insurance company.
m. There is no Co- payment including Maternity Cases.
n. Treatment can be availed anywhere in India and claims shall be settled in Indian Rupees only.
p. In case of reimbursement / payment it will be directly credited to employee's account for which employee have to enclose a copy of cancel cheque for crediting the amount.

5. MAJOR EXCLUSIONS:

The following shall be excluded from the coverage of the Policy:

a. Injury or diseases directly or indirectly caused by or arising from or attributable to invasion, war (whether declared or not), act of foreign enemies, etc.
b. Circumcision unless necessary for treatment of a disease covered by the policy.
c. Cosmetic treatment or plastic surgeries other than those necessitated by an accident or any illness.
d. Cost of spectacles, contact lens or hearing aids.
e. Dental treatment or surgery unless requiring hospitalization.
f. Convalescence, general debility, run down condition, congenital external disease or defects, venereal disease etc.
g. Medical treatment because of intentional self- injury or consumption of intoxicating drugs or alcohol.
h. AIDS or any of its variant.
i. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.
j. Hospitalisation solely for the purpose of testing shall not be covered.
k. Injury/ disease directly or indirectly caused by or contributed to or by any nuclear weapon/ material.
l. Naturopathy Treatment
m. Domiciliary Hospitalization

6. CONDITIONS:

The following conditions shall be applicable to the Group Medical Insurance Policy:

a. Hospitalization benefits shall be extended only if the in-door treatments for 24 hours or more.
b. Bifurcation of Bill in which all the details of the hospitalization and medicines are mentioned shall be a mandatory requirement.
c. Reimbursement Claim shall have to be filled within 7 days from the date of discharge from Hospital.
d. Intimation within 24 hours of hospitalization shall have to be given to the Insurance Broking Company.
e. Any change during the Policy Period in the designation shall not necessitate any change in the Sum Insured. Such change in the Sum insured due to change in designation shall only be incorporated at the time of renewal of the Policy.

7. PROCESS:

The Settlement of the Medical Expenses shall be of the three ways which are mentioned as below:

a. Process to be followed in case of Cashless Claims:

I. Employees, their dependents or any other person accompanying the covered employee and his family shall have to approach hospital with E- Card & an Identification Proof.
II. Hospital shall send intimation to the TPA.
III. The TPA shall then authorize the hospital as per eligibility of the employee.

b. Process to be followed in case of Claiming in Network Hospital:

I. Intimation shall have to be sent to Insurance Broking Company within 24 Hours of Hospitalization.
II. The employee shall have to fill up the Reimbursement Claim form as per the **Annexure 1.**
III. The employee shall collect documents as per the checklist provided in **Annexure 2.**
IV. All the original documents/ bills/ reports/ investigations shall have to be forwarded to Insurance Broking Company for document Verification.
V. The Insurance Broking shall forward the complete documents to the Third Party Administrators for Processing of Claim/Medical Scrutiny.
VI. After the claim is processed, the TPA shall process the cheque and shall inform the Insurance Broker who in turn shall inform the employee/ representative from organization regarding settlement of Claim.

c. Process to be followed in case of Claiming in Non- Network Hospital:

I. Employee shall avail treatment at any hospital and shall make upfront payment.
II. Intimation shall have to be sent to Insurance Broking Company within 24 Hours of Hospitalization.
III. The employee shall have to collect documents as per the checklist provided in Annexure 2.
IV. Employee shall have to submit all the bills to Insurance Broking Company for verification.
V. Insurance Broking Company shall send the complete and verified documents to the TPA who shall process the claim and provide the cheque.

8. SUM INSURED:

The Sum Insured of an Employee shall be determined by his designation in the Organization as per mentioned below:

DESIGNATIONS	SUM INSURED
Director/ CEO	5.00 Lacs
President/ COO/ Vice President	5.00 Lacs
Asst. Vice President/ Sr. Gen Mgr./ Gen Mgr.	4.00 Lacs
Dpty Gen Mgr/ Asst. Gen Mgr.	4.00 Lacs
Sr. Manager/ Mgr/ Dy. Mgr/ Asst. Mgr	3.00 Lacs
Sr. Exec/Sr. Engg./Engg/ Exec./Jr. Engg/ Jr. Exec.	2.00 Lacs
Below Jr. Engineer/ Jr. Executive	1.00 Lac

9. ANNUAL RENEWAL PROCEDURE:

The Policy shall be renewed in May every year. The following procedure shall be followed at the time of renewal of the Policy:

Step No.	Action to be taken	Responsible Person	Date/ Timeline
1	Initiation of the procedure	Insurance Broking Company	1st September
2	Filled forms to be sent to Corporate	Site HR/ Plant HR	12th September
3	Filled forms to be compiled & submitted to Insurance Broking Company	Corporate HR	17th September
4	Insurance Broking Company shall compile all the data, calculate the premium & communicate the same to Corporate HR	Insurance Broking Company	22nd September
5	The Corporate HR shall get premium approved from the Management &the cheque shall be sent to the Insurance Broking Company	Corporate HR	27th September
6	The Insurance Broking Company shall get the Policy renewed & the Policy document ready& provide the same to the Company.	Insurance Broking Company	5th October

10. PROCEDURE FOR NEW JOINEE'S & EMPLOYEE'S LEAVING COVERAGE:

The following procedure shall have to be followed in case of New Joinees and Employees Leaving the Organization:

a. All employees who join the Organization shall be covered under the Policy from the Date of his Joining after submission of required details as per the Mediclaim Enrolment Form as per **Annexure 3.**

b. The addition and deletion data of every preceding month shall be sent in 1st week of succeeding month from Corporate HR to the Insurance Broking Company.

c. In case if a New Joinee is hospitalized before the addition data for the previous month is sent to the Insurance Broking Company, a mail from the HR confirming the Claimant's Date of Joining shall be sent to the Insurance Broking Company who will send the same to the Insurance Company. The Insurance Company shall upload the data on urgent basis and then the endorsement shall be issued to the TPA who will give the approval as per policy terms.

d. An Employee who leaves the Organization shall be uncovered from the Policy from the date of his Leaving. e. Likewise, the deletion data of every preceding month shall be sent in 1st week of succeeding month from Corporate HR to the Insurance Broking Company.

11. CHANGE IN DEPENDENTS:

The change in dependents shall be made as per the following procedure:

a. Any changes in the dependent shall have to be notified to Corporate HR through the Site HR/ Plant HR who shall inform the same to the Insurance Broking Company for the necessary amendments.

b. The addition and deletion data of every preceding month shall be sent in 1st week of succeeding month from Corporate HR to the Insurance Broking Company.

c. Only newly wedded spouse and new born babies can be added in the dependents of an employee during the year.

d. Any other change in the dependents can be made at the time of renewal of the Policy.

e. The form that shall be filled at the time of change in dependents shall be same as medical enrolment form as per Annexure - 4.

12. PROCESS OF E-CARDS:

The Company's Medical Insurance Policy has been enrolled with **Paramount Health Services and Insurance TPA Private Limited.** The access to E- Card and other information regarding the Policy can be made by logging on to the TPA website i.e. www.paramounttpa.com .The Site/Plant HR shall be responsible for obtaining the E- Cards for Site/ Plant Employees and distribute the same to all employees.

13. FRAUDULENT CLAIMS:

At any point of time, if it is gathered that the claim by an employee is fraudulent, the same shall be viewed as a major miss-conduct. In case of such major miss-conduct, the management shall have the right to initiate the severest disciplinary action against the errant employee. This disciplinary action shall be over and above the recovery of the amount of Medical Reimbursement, claimed or reimbursed, from the employee's account.

14. HANDLING OF GREIVANCES & FEEDBACK TO EMPLOYEES:

The Site/Plant HR shall be responsible for handling the grievances related to the settlement of Claims and shall communicate all the important and relevant information regarding their claims with the employees. In this regard, the Insurance Broking Company as appointed by our Organization which shall be taking care of all the Policy related matters is **Unison Insurance Broking Services Pvt. Ltd**. Mr. Praveen Kulashri from the Unison Insurance Broking Services shall be the relationship Manager and Single point of contact for all servicing related issues. Contact details of **Mr. Praveen Kulashri** are as under:

Mobile Number: 9560041214, Email: praveen.kulashri@unisoninsurance.net
Escalation to - Mr**. Shivam Pal**: Mobile Number**: 09818084814**, Email: **shivam.pal@unisoninsurance.net**

For any quarries on your reimbursements you may contact as follow.

Level	Name	Contact No	Email IDs'
First Level	Mr. Safeek Ahmed	7042391036	Safeek.ahmad@paramounttpa.com
Second Level	Mr. Vijay Tiwari	9350293045	Vijay.tiwari@paramounttpa.com
Third Level	Mr. Suman Tilak	9313887045	Suman.tilak@paramounttpa.com

All Site/Plant HR shall contact Mr. Kulashri for any grievances/issues/queries regarding settlement of claims. In case there is any change in the Relationship Manager, the same shall be intimated to Site/Plant HR by the Corporate HR.

15. POWER TO AMEND:

a. Any change of the guideline shall be approved by the Head – Group Corporate HR.

b. The management shall have the overriding right to withdraw and / or amend the guideline at its own discretion as it deems fit from time to time. The decision of the management shall be final and binding.

Annexure 3

DEPENDANTS DECLARATION FORM UNDER THE COMPANY GROUP MEDICAL INSURANCE SCHEME

(Employees' are advised to retain a copy of this form)

Name Of Employee		**Employee Code**	
Designation/Deptt./Company		**Location**	

SL. NO	NAME	RELATION with employee	Sex (M/F)	Date Of birth	Age as on 31stMarch,2018
1		**Self**			
2					
3					
4					

(Note – The Scheme covers the immediate family of the employee, that means self, spouse, dependant son and daughter. Parents, brother, sisters etc are not covered.)

Signature of Employee

DEPENDANTS DECLARATION FORM UNDER THE COMPANY GROUP MEDICAL INSURANCE SCHEME

(Employees' are advised to retain a copy of this form)

Name Of Employee		**Employee Code**	
Designation/Deptt./Company		**Location**	

SL. NO	NAME	RELATION with employee	Sex (M/F)	Date Of birth	Age as on 31stMarch,2018
1		**Self**			
2					
3					
4					

(Note – The Scheme covers the immediate family of the employee, that means - self, spouse, dependant son and daughter. Parents, brother, sisters etc are not covered.)

Signature of Employee

Back To Index

ANNEXURE 1

PARAMOUNT HEALTH SERVICES & INSURANCE TPA PRIVATE LIMITED (IRDA License No. 006)			
[formerly known as PARAMOUNT HEALTH SERVICES (TPA) PVT.LTD]			
Plot no.A-442, Road No-28,M.I.D.C Industrial Area, Wagale Estate, Ram Nagar, Vitthal Rukmani Mandir, Thane (W), Mumbai, Pin Code – 400 604			
CLAIM ACKNOWLEDGMENT SHEET			
Name of Insurer :		**PHS ID :**	
Insured Name :		**Employee No :**	
Patient Name :		**Mobile No :**	
Policy No :		**Phone (STD) :**	
Name of Corporate:			
Type of Claim (To be ticked) :	Main Hospitalisation / Pre-Post Hospitalisation / OPD Claim / Deficiency Retrieval / Critical Illness / Cash Benefit	**E-Mail ID of primary insured :**	
CLAIM DOCUMENT CHECK LIST			
Sr. No	**Description**	**Document Status(Y/N)**	**Remarks**
1	IRDA Claim Form duly signed by the Insured & Hospital		
	Part-A: Duly signed by the insured with Claimed amount ,Mobile number & Email ID along with PHS ID		
	Part-B: Duly signed and stamped by hospital		
	Declaration form duly signed & stamped by the hospital in case treatment taken is under PPN/GIPSA hospitals.		
2	In case of No Intimation / Delay Intimation & Delay in submission of claim, a letter from insured is required stating reason for the same.		
3	Original Cancelled Cheque Leaf of Employee/Proposer with the Name of the AccountHolder Printed on the Cheque Leaf.		
4	ID Proof of Employee / Primary Insured- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID) . If Claim is above 1 lakh- PAN is mandatory with address Proof		
5	ID Proof of Patient- Any of one (Passport,Voter ID, Driving License, Or any Government Approved ID)		
6	Original detailed Discharge Summary as per IRDA Format / Day care summary from the hospital (in case of Day Care Treatment) / Death Summary (in Case of Death Claim)		
6.a	Copy of the Legal heir certificate (if the claim is for the death of the principle insured)		
6.b	Copy of Post Mortem Report & Death Certificate (In Accidental Death cases)		
7	Policy Copy **(if individual policy)**		
8	64VB Compliance Certificate **(If individual policy)**		
9	Original Final Hospital bill with cost wise breakup of each Item		
10	Original Payment Receipt of Main Hospital bill (both Deposit / Refund)		
10.a	Receipt Of Payments made at the Hospital by Credit Card : Please attach the Xerox Copy of the Credit Card Payment Slip as received from the Vendor		
11	Original copy of Implant Invoice along with Payment Receipts & Implant Labels / Stickers for Stents/ Mesh/ IOL		
12	Original bills, original Payment Receipts and investigation / Laboratory Reports		
13	Original medicine bills specifying Patient Name and date of purchase along with supporting Prescriptions.		
14	Original copy of First Consultation letter and subsequent Prescriptions.		
15	Hospital Registration certificate issued by Competent authority as per Indian nursing council Act 1947 (If hospital not falls in GIPSA/PPN)		
16	**OTHER DOCUMENTS**		
16.a	Original copy of Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor. (Maternity Claim)		
16.b	Original Sonography Report in case of Maternity Claim		
16.c	Original A-Scan Report along with IOL Sticker and Tax paid invoice in case of Cataract Claim		
16.d	Copy of the First Information Report (FIR) from Police Department / Copy of the Medico-Legal Certificate (MLC) in case of Road Traffic Accident (RTA)		
16.e	A medical certificate from a doctor not less qualified than MD/MS confirming the diagnosis of critical illness along with the Investigation reports/Other related documents reflecting the critical illness diagnosis. (Critical Illness Cases)		
16.f	In case of claims where the insured has submitted documents to another insurance co/TPA, he needs to submit attested Photocopies of all the documents along with detailed claim settlement letter from the TPA and any unpaid bills and receipt for the same in originals.		
Claims Submitted by : Insured / Corporate / Agent / Broker / Insurer / Hospital			
Claim Submitted by:		**Mobile No.**	
Date of Claim Submission:	DD/MM/YYYY HH:MM	**PHS Executive Name:**	
Claim Submitted at:	PHS - (Location) / Help Desk	**Signature:**	
Important Points to Remember:-			
1. Please mark either **√** **or** **×** against respective check box			
2. Date of File Received will be considered as next working day for Claim Files picked up at Help Desk			
3. Claim Need to be Submitted within 7 Working Days from Date of Discharge from Hospital			
4. The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our document recovery team will contact you on receipt of your claim documents by us			
5. Please visit us at www.paramounttpa.com to check Online Claim Status or download Paramount Mobile App			
6. Member is advised to keep photocopies of all the papers since Insurer requires all the above documents in original. Documents once submitted will not returned unless approved & agreed by Insurer			
7. Corrections in any documents are not allowed, otherwise it will not be entertained during adjudication.			

Back To Index

Annexure - III

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:
c) Company/ TPA ID No:
d) Name : SURNAME FIRST NAME MIDDLE NAME
e) Address :
City: State:
Pin Code: Phone No: Email ID :

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y (Copies of Policies to be attached)
c) If yes, company name: Policy No.
Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? Yes No Date: M M Y Y Diagnosis:
e) Previously covered by any other Mediclaim / Health insurance : Yes No f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME
b) Gender: Male Female c) Age: years Y Y months M M d) Date of Birth: D D M M Y Y
e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)
f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)
g) Address (if different from above):
City: State:
Pin Code: Phone No: E-mail ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:
b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room
c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y
e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M
i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption i. If Medico legal: Yes No
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs.
iii. Post-hospitalization Expenses: Rs. iv. Health-Check up Cost: Rs.
v. Ambulance Charges: Rs. vi. Others (code): Rs.
Total **Rs.**
vii. Pre-hospitalization period: days viii. Post-hospitalization period: days
b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)
c) Details of Lump sum / cash benefit claimed:
i. Hospital Daily Cash: Rs. ii. Surgical Cash: Rs.
iii. Critical Illness Benefit: Rs. iv. Convalescence: Rs.
v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.
Total **Rs.**

Claim Documents Submitted- Check List:

- Claim Form Duly signed
- Copy of the claim intimation
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills:___Nos	
3.		D D M M Y Y		Post-hospitalization Bills:___Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:
c) Bank Name and Branch:
d) Cheque/ DD Payable details: e) IFSC Code:

SECTION A SECTION B SECTION C SECTION D SECTION E SECTION F SECTION G

(IMPORTANT: PLEASE TURN OVER)

\\Back To Index

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, 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.

SECTION H

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

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) 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
d) Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) 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
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) 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
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Back To Index

Annexure - III

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

d) Name of the treating doctor: SURNAME FIRSTNAME MIDDLENAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRSTNAME MIDDLENAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH : MM h) Date of Discharge: DD MM YY i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: DD MM YY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details)

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No

v. FIR no. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:

City: State:

Pin Code: b)Phone No. c) Registration No.:

d) PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No

iii. Others :

SECTION F

DECLARATION BY THE INSURED **(PLEASE READ VERY CAREFULLY)**

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, 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: DD MM YY Place: Signature of the Insured:

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: DD MM YY

Place: Signature and Seal of the Hospital Authority:

SECTION G

Back To Index

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network nospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
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
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No.	Enter the registration number of patient	As allocated by the Hospital
d) PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient Beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

Back To Index

Annexure - 2 **Claimant Details**

Patient Name

Employee / Insured Name

TPA ID Card

E-Mail ID for Auto Mailers

Contact Detail for SMS update : Employee ID:

Company / Insurance Company Name :

Bank Name IFS Code and Account Number:

Hospital Name: Date of Admission-…….

Location: Date of Discharge-

……..

Type of Claim: Day Care Hospitalization Pre & Post Hospitalization

All documents required in original and we request you to keep one photocopy set of documents submitted for claims with you.

S.NO.	PARTICULARS	SUBMITTED (YES/NO	NO. OF DOCUMENTS
1	Completed Claim Form duly signed and stamped		
2	Day Care Summary/Discharge Summary		
3	Final Hospital Bill with Breakup		
4	First Prescriptions/Casualty Card /OPD Card		
5	Medicines Receipts with Supportive Prescriptions		
6	Investigation/Path. Reports in support of Diagnosis		
	X-RAY/MRI /CT–SCAN/ECG		
	USG /BLOODREPORTS/URINEREPORTS		
	OTHER REPORTS(Please Specify)		
7	Numbered Payment Receiptsagainst**3/4/5/6**		
8	Invoice and Sticker of Implant/Lens		
9	In Case of Accident Documents Required		
A	Copy of MLC/FIR		
	Uihhybhu		

Total Number Of Documents Submitted **Original**
Photocopy

Note – 1) Films for Investigations are must to be submitted along with the reports claimed.

2) In case of any Difficulty Please contact **UNISON Relationship Manager**.

Back To Index