# GROUP MEDICLAIM INSURANCE POLICY

**Extensions Opted**

1. Basis of Sum Insured: Family Floater, Basis of Premium: Per Life,
   Family Definition: (1+3), Relations Covered: Employee + Spouse + 2 Dependent Children
2. Maternity Benefit Extension: Not Covered
3. Forty eight (48) months Waiting Period for Pre-existing Diseases: Waived off
4. First thirty (30) days Waiting Period: Waived off
5. One (1) year Waiting period for specified Diseases: Waived off

**Special Conditions**

1) In-Patient Treatment: Covered
2) Day Care Cover: Covered
3) Domiciliary Hospitalization Expenses: Covered
4) Pre and Post Hospitalization Expenses: Covered
5) New born baby is covered from 91st Day of age within Family Floater Sum Insured
6) Emergency Ambulance Expenses: Covered upto 1% of Sum Insured maximum upto Rs. 2,000.00 per claim allowed for Insured person's transportation to nearest hospital on Medical Practitioner's advice.
7) Additions and Deletions of Employee / Dependent will be done on prorate basis from day 1 for additions subject to sufficient CD balance being maintained. Addition / Deletion of an Employee / Dependent must be intimated within 30 days from the Date of Joining / Date of Releaving.
8) Maximum age for Employee, Spouse shall be 80 years and dependent children shall be covered upto 25 years if the child is in full time education. (subject to their coverage in the policy)

9) Dependents to be declared at the time of inception of the policy. No midterm inclusion of Dependents allowed except for spouse after marriage and child by birth. Addition of family members must be intimated within 30 days after marriage or child birth. (subject to their coverage in the policy)
10) No individual can be covered more than once in the policy – specifically if an employee and spouse are working for the same organization both cannot cover each other and cannot cover same set of Parents, In case at the time of claim it is found that the member is covered twice a deletion endorsement of member will be effected to remove that member there will be no refund for such deletions.
11) It shall be a condition precedent to the Company's liability under this policy that all supporting documents relating to the claim must be submitted within thirty (30) days from the date of discharge from the hospital. In case of post-hospitalization treatment days, all claim documents should be submitted to the TPA within seven (7) days after completion of such treatment.
12) Surcharges, service charges, miscellaneous charges & other non treatment related expenses are not payable
13) Point no (4) (2) (c) (xiv) of part II Claims procedure in the attached wording pertaining to "For Non-Network hospitalizations, an insured person shall make co-payment of 10 percent of admissible claim amount. The co-payment amount shall be deducted from the claims reimbursable and the balance shall be paid to the Insured Person or Policy holder at the sole discretion of the TPA / Company" Stands Deleted.
14) The Policy excludes treatment for Psychiatric, mental disorders (including mental health treatments) and sleep-apnoea, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down condition"), External Congenital Anomaly, Genetic, Hereditary and related disorders.
15) The policy excludes the experimental / unproven treatments or therapies. The policy also excludes AYUSH coverage, Stem Cell Therapy, treatment with Injection Avastin/ Injection Remicade, Oral Chemotherapy, Cyber Knife treatment, Cochlear Implant Procedure, Lasik procedure, Femtolaser, Robotic surgery and allied treatments.

## Check List of Documents for GMC

### General Documents – (Applicable for all types of claims) –

- ✓ Duly filled and signed Claim Form
- ✓ Photocopy of ID card / photocopy of current year policy

## Specific Documents – Benefit wise

### *In-Patient Treatment / Day Care Procedures / Ayush Benefit*

- ✓ Original detailed discharge summary / day care summary from the hospital
- ✓ Original consolidated hospital bill with breakup of each Item, duly signed by the insured
- ✓ Original payment receipt of the hospital bill
- ✓ First consultation letter and subsequent prescriptions
- ✓ Original bills, original payment receipts and reports for investigation
- ✓ Original medicine bills and receipts with corresponding prescriptions
- ✓ Original invoice/bills for implants (viz. Stent /PHS Mesh / IOL etc.) with original payment receipts

### *Road Traffic Accident (In addition to the In-Patient Treatment Documents)*

- ✓ Copy of the first information report from police department / copy of the medico-legal certificate

### *In Non Medico Legal cases*

- ✓ Treating doctor's certificate giving details of injuries (How, when and where injury sustained) including whether claimant was under the influence of any intoxicating material.

## *In Accidental Death cases*

- ✓ Copy of post mortem examination report & death certificate

## *For Death Cases (In addition to the In-Patient Treatment Documents)*

- ✓ Original death summary from the hospital
- ✓ Copy of the death certificate from treating doctor or the hospital authority
- ✓ Copy of the legal heir certificate, if the claim is for the death of the principle insured
- ✓ Viscera Report for death due to poisoning OR snake bite

## *Pre- and Post-Hospitalization Expenses*

- ✓ Original medicine bills, original payment receipt with prescriptions
- ✓ Original investigations bills, original payment receipt with prescriptions and report
- ✓ Original consultation bills, original payment receipt with prescription
- ✓ Copy of the discharge summary of the main claim

## *Ambulance Benefit*

- ✓ Original bill with original payment receipt
- ✓ Treating doctor's consultation prescription indicating emergency hospitalization

# Extensions Opted

## 1.1 FAMILY FLOATER EXTENSION

In consideration of additional premium received by the Company from the POLICYHOLDER, it is hereby declared and agreed that the cover under the policy is extended to provide FAMILY FLOATER EXTENSION. Accordingly, amendments made to the policy are given below:

The following shall be incorporated in Preamble after "…., for the person in any one period of insurance as mentioned in the Schedule hereto."

"against the INSURED PERSON who is an employee / member of the POLICYHOLDER provided that notwithstanding anything to the contrary contained in the policy, the aggregate of all claims in any one PERIOD OF INSURANCE in respect of all IMMEDIATE FAMILY MEMBERS of the said employee / member who are named in the Schedule, shall not exceed PER OCCURRENCE, Sum Insured or ANY ONE YEAR LIMIT as the case may be indicated in the Schedule for the said employee / member.

All other terms and conditions of the policy remain unchanged

## 1.2 PRE-EXISTING CONDITION EXTENSION

In consideration of additional premium received by the Company from the **POLICYHOLDER**, notwithstanding anything to the contrary contained in any term, condition or exclusion of the policy or endorsement(s) thereto, the scope of cover under the policy is widened so as to pay claims arising out of a **PRE-EXISTING CONDITION**.

All other terms and conditions of the policy remain unchanged.

## 1.3 30 DAY WAITING PERIOD ENDORSEMENT

In consideration of additional premium received by the Company from the **POLICYHOLDER**, clause 3.2 of the policy under Section 3 titled **EXCLUSIONS** shall be deleted.

All other terms and conditions of the policy remain unchanged.

## 1.4 FIRST YEAR COVERAGE EXTENSION

In consideration of additional premium received by the Company from the POLICYHOLDER, the policy shall be amended as under:

1) Delete clause 3.3 of the policy under Section 3 titled EXCLUSIONS.
2) Incorporate the words "or congenital internal DISEASE or defect" between the "… or INJURY" and "for which medical advice," in the definition of PRE-EXISTING CONDITION at clause 2.43 of the policy.

All other terms and conditions of the policy remain unchanged.