

INDUSIND - GROUP MEDICLAIM SUPER TOPUP INSURANCE - CUSTOMER INFORMATION SHEET

CUSTOMER INFORMATION SHEET: PLAN B (DESCRIPTION IS ILLUSTRATIVE AND NOT EXHAUSTIVE)			
SI. NO.	TITLE	DESCRIPTION	Refer to Policy Clause Number
1.	Product Name	INDUSIND GROUP MEDICLAIM SUPER TOPUP INSURANCE - Plan B	
Built in Covers			
2.	What am I covered for	a. Medical Expenses: This cover indemnifies the Insured Person for medical expenses against illness/injury that requires Inpatient and Day Care Treatment up to the Sum insured. It also covers Pre and Post Hospitalization for 60 and 90 days respectively. This shall also cover Day Care Treatment.	3.1
		b. Domiciliary Hospitalization: Reasonable and Customary charges are payable for medical expenses incurred during Domiciliary Hospitalization as defined under this Policy, provided that the condition for which the medical treatment is required continues for at least three continuous and completed days.	3.2
		c. Maternity Cover: This Cover indemnifies the Insured Person up to Rs. 1 lakh for the maternity expenses including pre-natal and post-natal hospitalization expenses incurred on Inpatient Treatment during the Policy Period. Benefit shall become available only after the expiry of 12 months from the date of inception of the first Policy with the Company. The payment under this benefit is limited to maximum two deliveries or termination(s) or either, during the lifetime of the Insured Person. This cover is available for Aggregate Deductible Rs. 2 lakhs and above.	3.3
		d. Organ Donor: This cover will indemnify the Policyholder/Insured Person up to the Sum Insured for the medical expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery conducted on insured person during the Policy period	3.4
		e. AYUSH Treatment: This cover indemnifies the Insured Person for Medical Expenses which are incurred on treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy up to the Sum Insured. The AYUSH treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.	3.5
		f. Ambulance: This cover indemnifies the Insured Person up to an amount of Rs. 3500 per Hospitalization for Expenses incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider.	3.6
		g. Modern Treatment Methods: Coverage up to 50% of S.I under this benefit for the medical expenses incurred during the Policy Period on Inpatient Treatment or Day care Treatment or Domiciliary Treatment of listed Modern Treatment Methods	3.7
		Optional Covers	
		h. Waiver of Waiting Period for Pre-Existing Disease: This Cover waives off the Pre-Existing Disease Waiting Period Condition in part or full	3.8
		i. Waiver of Waiting Period for Specified disease/procedure: This Cover waives off the Waiting Period Condition for Specified disease/procedure listed in Section 4 (ii) of the Policy wording	3.9
		j. Waiver of 30 days Waiting Period: This Cover waives off the Initial 30 Days Waiting Period Condition.	3.10
		k. Waiver of Waiting Period for Maternity Cover: This Cover waives off the Maternity Cover Waiting Period Condition.	3.11
		l. Room Rent Limit: This cover allows the Policyholder to apply sublimit to ICU and non ICU Room Rent charges by adding Percentage and Rupee limits	3.12
		m. Change in Pre and Post Hospitalization limit: This cover provides an option to change the Pre and Post hospitalization coverage period from 60 days to 30 days and from 90 days to 60 days respectively	3.13


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3.	What are the major exclusion in the policy	Following is a partial list of the policy exclusions. Please refer to the policy document for the complete details of exclusions: a. Investigation & Evaluation (Code:Excl04) b. Rest Cure, rehabilitation and respite care (Code:Excl05) c. Obesity/Weight Control (Code:Excl06) d. Change-of-Gender treatments (Code:Excl07) e. Cosmetic or Plastic Surgery (Code: Excl08) f. Hazardous or Adventure sports (Code:Excl09) g. Breach of law (Code: Excl10) h. Excluded Providers (Code:Excl11) i. Substance Abuse and Alcohol (Code: Excl12) j. Wellness and Rejuvenation (Code:Excl13) k. Dietary Supplements & Substances (Code: Excl14) l. Refractive Error (Code: Excl15) m. Unproven Treatments-Code (Code: Excl16) n. Sterility and Infertility (Code: Excl7) o. Aggregate Deductible p. Dental Treatments q. External Congenital Anomaly r. Treatment other than Medically Necessary Treatment s. Non-medical expenses t. Outpatient treatment u. Overseas treatment v. Charges other than Reasonable & Customary Charges w. Self-injury or suicide x. Treatment outside discipline y. War z. Wilful Act/Negligence	5
4.	Waiting Periods	a. 24/36 months waiting period for Pre-Existing Disease (Code: Excl01) b. 24 months waiting period for Specied disease/procedure waiting period code (Code:Excl02) c. 30 Days Waiting Period (Code:Excl03) d. 12 months waiting period for Maternity Cover	4
5.	Payment Basis	Payment for all covers are on Indemnity Basis	
6.	Renewal Condition	The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.	7(15)
7.	Cancellation	a. The Insured may cancel this Policy by giving written notice. If no claims have been made, the Company shall refund premium for the unexpired Policy Period as per the rates detailed in the policy terms and conditions. b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice.	7(26)
8.	Claims	a. For Cashless Service: Insured may refer Pre-Authorization form attached as Annexure-C to the Policy Wordings and for updated Hospital Network details refer the link https://www.indusindinsurance.com/Insurance/Self-Help/Cashless-Garagesand-Hospitals.aspx?network=Hospitals b. For Reimbursement of Claim: For reimbursement of claims the insured person may submit the necessary documents to TPA/Company within the prescribed time limit as specified hereunder.	6


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		<table><tr><th>SI No.</th><th>Payment Basis</th><th>Prescribed Time limit</th></tr><tr><td>1.</td><td>Reimbursement of hospitalization, day care and pre hospitalization expenses</td><td>Within thirty days of date of discharge from hospital</td></tr><tr><td>2.</td><td>Reimbursement of post expenses post hospitalization treatment</td><td>Within fifteen days from completion of hospitalization</td></tr></table> For details on claim procedure please refer the policy document	SI No.	Payment Basis	Prescribed Time limit	1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital	2.	Reimbursement of post expenses post hospitalization treatment	Within fifteen days from completion of hospitalization	
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9.	Policy Servicing	Any issues related with respect to policy, kindly E-mail us at services@indusindinsurance.com and for correspondence contact us IndusInd General Insurance, For correspondence contact us IndusInd General Insurance, South Wing, 4th Floor, Off Western Express Highway, Santacruz (E), Mumbai - 400055										
10.	Grievances/ Complaints	a. Details of Grievance redressal officer refer the link (https://www.indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx) b. IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/ c. Insurance Ombudsman - The contact details of the Insurance Ombudsman offices have been provided in the Policy document	7(32)									
11.	Insured's Rights	a. Free Look period of 15 days from the date of receipt of the first policy shall be available. b. Lifelong renewability (except on certain specific grounds) c. Right to migrate from one product to another product of the company (E-mail us at services@indusindinsurance.com and For correspondence contact us IndusInd General Insurance, South Wing, 4th Floor, Off Western Express Highway, Santacruz(E), Mumbai - 400055) d. Right to port the from one company to another company (E-mail us at services@indusindinsurance.com and For correspondence contact us IndusInd General Insurance, South Wing, 4th floor, Off Western Express Highway, Santacruz (E), Mumbai - 400055) e. Change in SI during the policy term or at the time of renewal E-mail us at services@indusindinsurance.com f. Norms on TAT for Pre-Auth and Settlement of reimbursement.	7(31), 7(15), 7(18), 7(19), (24)									
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12.	Insured's Obligations	Please disclose all material facts before buying a policy. Non-disclosure may result in claim not being paid and policy getting cancelled without refund of premium.	7(1)									

Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.


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PRE-AUTHORISATION FORM - ANNEXCURE C

INDUSIND GENERAL INSURANCE COMPANY LIMITED REQUEST FOR CASHLESS HOSPITALISATION HEALTH INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA / Insurance Company:	
b) Toll free phone number:	
c) Toll free FAX:	

TO BE FILLED BY THE INSURED / PATIENT

a) Name of Patient	o Mr. o Mrs. o Ms. F I R S T M I D D L E L A S T		
b) Gender:	o Male o Female	c) Age:	Years Y Y Month M M
d) Date of birth:	D D / M M / Y Y Y Y	e) Contact number:	
f) Contact number of attending relative:		g) Insured card ID Number:	
h) Policy number / Name of Corporate:		i) Employee ID:	
j) Currently do you have any other Mediclaim / Health insurance:			o Yes o No
If yes, company name:			
Give details:			
k) Do you have a family physician:			o Yes o No
If yes, name of the family physician:			
Contact number, if any:			

(Please complete declaration on Page 3 of this form)

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor:	o Mr. o Mrs. o Ms. F I R S T M I D D L E L A S T		
b) Contact number of the treating doctor:			
c) Nature of illness / disease with presenting complaints:			
d) Relevant clinical findings:			
e) Duration of the present ailment:	_____ days		
i. Date of first consultation:	D D / M M / Y Y Y Y		
ii. Past history of present ailment if any:			
iii ICD 10 code:			
f) Provisional diagnosis:			

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

g) Proposed line of treatment:	☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non-allopathic treatment
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h) If investigation and/or medical management, provide details			
i. Route of drug administration:			
i) If surgical, name of surgery:			
i. ICD 10 PCS Code:			
j) If other treatments, provide details:			
k) How did injury occur?			
l) In case of accident:			
i. Is it RTA:	☐ Yes ☐ No	ii. Date of injury:	DD / MM / YYYY
iii. Reported to police:	☐ Yes ☐ No	iv. FIR number:	
v. Injury/disease caused due to substance abuse/alcohol consumption:			☐ Yes ☐ No
vi. Test conducted to establish this:	☐ Yes ☐ No (If Yes, attach reports)		
m) In case of maternity:	☐ G ☐ P ☐ L ☐ A	i. Date of delivery:	DD / MM / YYYY

DETAILS OF PATIENT ADMITTED

a) Date of admission:	DD / MM / YYYY	b) Time:	HH / MM
c) Is this an emergency/a planned hospitalization event?:	☐ Emergency ☐ Planned		
d) Expected no. of days' stay in hospital:	_____ Days		
e) Room type:			
f) Per day room rent + nursing and service charges + patient's diet:	₹		
g) Expected cost for investigation and diagnostics:	₹		
h) ICU charges:	₹		
i) OT charges:	₹		
j) Professional fees Surgeon + Anaesthetist fees + Consultation charges:	₹		
k) Medicines + Consumables + Cost of implants (if applicable please specify, other hospital expenses):	₹		
l) All inclusive package charges if any applicable:	₹		
m) Sum total expected cost of hospitalization:	₹		

MANDATORY: PAST HISTORY OF ANY CHRONIC ILLNESS	If yes, since (month / year)
☐ Diabetes	MM / YYYY
☐ Heart disease	MM / YYYY
☐ Hypertension	MM / YYYY
☐ Hyperlipidemias	MM / YYYY
☐ Osteoarthritis	MM / YYYY
☐ Asthma/COPD/Bronchitis	MM / YYYY


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☐ Cancer	MM / YYYY
☐ Alcohol or drug abuse	MM / YYYY
☐ Any HIV or STD/Related ailments	MM / YYYY

Any other ailment give details:

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read, understood and agreed to the Declarations on page 3 of this form:

a) Name of the treating doctor:	
b) Qualification:	
c) Registration number with state code:	

Hospital seal (Must include Hospital ID)

Patient/Insured name and signature

DECLARATION BY THE PATIENT/ REPRESENTATIVE:

- I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer after the discharge. I agree to sign on the final bill & the discharge summary, before my discharge.
- Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- All non-medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the Insurer not governed by the terms and conditions of the policy will be paid by me.
- I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the Insurer.
- I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer.

Patient's/Insured's Name: _____

Contact number: _____

Patient/Insured name and signature

HOSPITAL DECLARATION:

- We have no objection to any authorized Insurance Company of official verifying documents pertaining to hospitalization.
- All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to Insurance Company within 7 days of the patient's discharge.
- All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Insurance Company, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
- WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
- The patient declaration has been signed by the patient or by his representative in our presence.
- We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- We will abide by the terms and conditions agreed in the MOU.



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Patient/Insured name and signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM:

1. Detailed discharge summary and all bills from the hospital
2. Cash memos from the hospitals/chemists supported by proper prescription.
3. Receipts and pathological test reports from pathologists, supported by note from the attending medical practitioner/surgeon recommending such pathological tests.
4. Surgeon's certificate stating nature of operation performed and surgeon's bill and receipt.
5. Certificates from attending medical practitioner/surgeon that the patient is fully cured.

