NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY Applicable for ICAI Members/Students/Employees

FAQ's:

WHO CAN TAKE THIS POLICY

This insurance is available to Registered Members of the Institute of Chartered Accountants of India, the Employees and Students of the Institute, not below the age of 18 years. Children between the age of 3 months and 25 years can be covered provided parents are covered simultaneously. Student's coverage is limited to Self and not available for the Dependants.

WHETHER THIS INSURANCE COVERS MATERNITY EXPENSES?

Pregnancy/Maternity/Child Birth either Normal or Caesarean are not covered under this insurance. Any Medically advised Termination of Pregnancy to save the life of Mother only Covered.

CAN I COVER MY FAMILY MEMBERS IN ONE POLICY?

Yes. You can cover Your family members in one policy. The members of the family who could be covered under the Policy under a single Sum Insured are:

a) Proposer

b) Proposer's Spouse

c) Proposer's two dependent Children Additional dependent children may be covered by paying 10% loading on family premium. There is also an option to cover the Proposer's dependent Parents for a separate Sum Insured up to the Sum Insured of the Proposer's family.

The number of persons to be covered under the policy is to be declared at the inception of the policy as a one-time option. Inclusion of additional dependents would be allowed only in case of marriage of the Insured person, or birth of a child. No other inclusion would be permitted either during the coverage of the policy, or at the time of renewal.

"ALSO, THE SELECTION OF SUM INSURED FOR DEPENDENT PARENTS IS A ONE-TIME OPTION AND CAN ONLY BE DONE AT THE TIME OF INCEPTION OF THE POLICY."

WHAT DOES THE POLICY COVER?

This Policy is designed to give You, the Insured, protection against unforeseen Hospitalisation expenses for treatment taken in India.

DOES IT COVER ALL CASES OF HOSPITALISATION?

No. This Policy does not cover all cases of Hospitalization. Hospitalisation expense relating to a Pre-Existing Disease is payable up to the as extent specified below: For members /employees/students without any previous continuous insurance, the coverage for pre-existing diseases would be subject to the following:

FIRST YEAR OF COVERAGE	25% OF THE ADMISSIBLE CLAIM AMOUNT, SUBJECT TO A MAXIMUM OF 25% OF THE SUM INSURED
SECOND YEAR OF COVERAGE	50% OF THE ADMISSIBLE CLAIM AMOUNT, SUBJECT TO A MAXIMUM OF 50% OF THE SUM INSURED
THIRD YEAR OF COVERAGE	100% OF THE ADMISSIBLE CLAIM AMOUNT, SUBJECT TO A MAXIMUM OF 100% OF THE SUM INSURED

Similarly, Hospitalization expenses for pregnancy are not covered under the Policy. There are other such instances, where the claim is not payable. Some of the exclusions are:

- Diseases contracted within 30 days of insurance. However, this exclusion is not applicable for persons with previous continuous insurance coverage.
- Debility and General Run-Down Conditions.
- Sexually transmitted diseases and HIV (AIDS)
- Circumcision, Cosmetic surgery, Plastic surgery unless required to treat injury or illness.
- Vaccination and Inoculation
- Pregnancy, ailments related thereto and childbirth.
- War, Act of foreign enemy, ionising radiation and nuclear weapon.
- Treatment outside India
- Naturopathy
- Domiciliary Treatment
- Experimental or unproven treatment
- All external equipment such as contact lenses, cochlear implants etc.

Payments made to the Hospital like Service Charges, Surcharge, cost of external or durable medical equipment, non-medical expenses, etc. are not payable. The exclusions stated above are not exhaustive. The exclusions are mentioned in the Policy under the Section 4 " EXCLUSIONS". You may go through the list of Exclusions to get to know what is NOT covered under the Policy.

WHAT IS A PRE-EXISTING DISEASE?

The term Preexisting condition/disease is defined in the Policy. It is defined as: "Any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or was diagnosed, and/or received medical advice/treatment, within 36 months prior to his/her first Policy with the Company.

If You had:

a) Signs or symptoms, or

b) Been diagnosed or received Medical Advice, or

c) Been Treated for any condition or disease within Thirty-Six months prior to the commencement of the first policy with us, such a condition or disease shall be considered as Preexisting. Any hospitalisation arising out of such preexisting disease or condition is not covered under the Policy, only to the extent specified under Clause 4, for those without any Continuous Insurance.

IS PRE-EXISTING COVERED IF I HAD PREVIOUS INSURANCE WITH ANY OTHER INSURER?

YES. Our Policy gives credit for the years' of previous insurance with any other non-life insurer, under a Hospitalisation Policy, provided You renew the Policy with Us, on the due date, or at the most within thirty days of the expiry of the Policy with the Previous Insurer. For instance, if you had Continuous Coverage with a previous Insurer for twenty-four months, and renew the policy with us on or before expiry date of the previous policy, or within thirty days thereof, pre-existing diseases would be fully covered. To put it shortly, this Policy treats your previous years of insurance with any insurer, as if you had been insuring with us.

IS HOSPITALISATION ALWAYS NECESSARY TO GET A CLAIM?

Yes. Unless the Insured Person is Hospitalised for a condition warranting hospitalisation, no claim is payable under the Policy. The Policy does not cover outpatient treatments.

HOW LONG DOES THE INSURED PERSON NEED TO BE HOSPITALISED?

The Policy pays only where the Hospitalisation is for more than twenty-four hours. But for certain treatments specified in the Policy, period of stay at the Hospital could be less than twenty-four hours. Please refer to Clause 3.14 of the Policy for details.

WHAT DO I NEED TO DO AFTER I GET HOSPITALISED?

Immediately on Hospitalisation and a maximum of within seven days of such Hospitalisation, please intimate the TPA of this fact, with details of Your Policy Number, Name of the Hospital and treatment undertaken. This is an important condition of the Policy that you need to comply with.

IS PAYMENT AVAILABLE FOR EXPENSES INCURRED BEFORE HOSPITALISATION?

Yes. Relevant medical expenses incurred before hospitalization for a period of THIRTY days prior to the date of hospitalisation are payable. Relevant medical expenses means expenses related to the treatment of the disease for which the insured is hospitalised.

IS PAYMENT AVAILABLE FOR EXPENSES INCURRED AFTER HOSPITALISATION?

Yes. Relevant medical expenses incurred after Discharge from the Hospital for a period of SIXTY days after the date of discharge are payable. Relevant medical expenses mean expenses related to the treatment of the disease for which the insured is hospitalised.

IS THERE A LIMIT TO WHAT THE COMPANY WILL PAY FOR HOSPITALISATION?

Yes. We will pay Hospitalization expenses upto a limit, known as Sum Insured. This Sum Insured represents our total liability under the Policy for all admissible claims of all Insured members under the Policy. In cases where the Insured Person or other insured members were hospitalised, the total of all amounts paid

a) for all cases of Hospitalisation,

b) expenses paid for medical expenses prior to hospitalisation,

c) expenses paid for medical expenses after discharge from hospital, and

d) any other payment made under the Policy shall not exceed the Sum Insured.

For each policy, the Sum Insured is on floater basis for all persons covered. In Floater basis, any payment made to one Insured Person would make the Sum Insured reduced for all Insured Persons. The total payments under this Policy for all Insured Persons for all claims during the Policy period shall not exceed the Sum Insured. However, since parents are covered under a separate floater Sum Insured, that separate Sum Insured would cover both the parents.

HOW LONG IS THE POLICY VALID?

The Policy is valid during the Period of Insurance stated in the Schedule attached to the Policy. It is usually valid for a period of one year from the date of beginning of insurance.

CAN THE POLICY BE RENEWED WHEN THE PRESENT POLICY EXPIRES?

Yes. You can and to get all Continuity benefits under the Policy, you should renew the Policy before the expiry of the present policy. For instance, if Your Policy commences from 2nd March 2011 date of expiry is usually on 1st March 2012. You should renew Your Policy by paying the Renewal Premium on or before 1st March 2012.

WHAT IS CONTINUITY BENEFIT?

There are certain treatments which are payable only after the Insured Person is continuously covered for a specified period. For example, any Pre-existing disease is covered only after four years of continuous insurance under a standard Mediclaim Policy. In the present Group Health Insurance Scheme of ICAI, however, Pre-existing illnesses are covered fully after continuous insurance for two years. Continuous insurance would mean insurance under a Hospitalization policy with any non-life insurer continuously without break. After such credit for previous continuous insurance, the amount payable for pre-existing illnesses would be:

If an Insured took a Policy in March 2012, does not renew it on time, and takes a Policy only in May 2013, and renewed it on time in May 2014, any claim for Pre-existing disease incurred in say, October 2014 would become payable only upto the extent of 50% of Sum Insured, because the Insured person was not continuously covered for twenty four months. If, he had renewed the Policy in time in March 2013 and then in March 2014, then he would have been continuously covered for twenty four months and therefore his claim for would become payable upto 100% of the Sum Insured, in the example cited. Therefore, you should always ensure that you pay your renewal Premium before Your Policy expires.

Continuity benefits are applicable only when a person shifts from one insurer to another or from one plan to another plan of the same insurer, for Sum Insured and time for which he has been covered under earlier policy. The additional Sum Insured in the new policy under this scheme will not have continuity benefits. Continuity benefits are subject to no break in between the previous policies as per the terms and conditions. At the time of claim you need to produce the previous 2 years' policy documents.

WHAT IS A NO CLAIM BONUS ?

Some of the Insurers, including Us, offer a Cumulative Bonus for years of claim free experience. This Cumulative Bonus represents an increase in Sum Insured available as a Bonus for claim free experience. For such persons with a Cumulative Bonus available in their Policy, we offer a Discount on Premium.

In the Group Health Scheme of ICAI, the Cumulative Bonus earned against any previous insurance policy of any insurer is protected by way of a discount on premium, the details of which are as below:

Cumulative Bonus of upto 10% - 5% discount in premium.

Cumulative Bonus of 10-30% - 10% discount in premium.

Cumulative Bonus of above 30% - 15% discount in premium.

The average Cumulative Bonus available to the family would be considered for the purpose of allowing discount.

This Discount is offered as a onetime measure, offered in lieu of Cumulative Bonus offered by the Previous Insurer. This discount would continue to be extended as long as no claim is reported under the Policy.

WHAT WILL HAPPEN TO DISCOUNT AGAINST CB IF THERE IS A CLAIM?

If there is claim during the current year, next year, there will be no Discount against CB, and whatever discount is allowed would stand withdrawn at the time of renewal. Even if the claim is for a smaller amount and for only one person in the family, the No Claim Discount will be withdrawn in the next year.

CAN THE SUM INSURED BE INCREASED AT THE TIME OF RENEWAL?

Yes, the sum insured can be increased at the time of renewal, if no claim is reported in the existing policy. Note-: The selection of sum insured of parents is one-time option and it can't be increased at the time of renewal of policy.

WHAT IS HOSPITAL CASH ALLOWANCE?

In case an Insured member is hospitalized for a period exceeding twenty-four hours, we pay an additional benefit @0.10% of the Sum Insured. This benefit is known as Hospital Cash Allowance. This benefit is limited to a maximum of ten days of Hospitalization for any illness.

IS THERE AN AGE LIMIT UPTO WHICH THE POLICY WOULD BE RENEWED?

No. Your Policy can be renewed, as long as You pay the Renewal Premium before the date of expiry of the Policy. There is no age limit for renewal. However, if You do not renew Your Policy before the date of expiry or within THIRTY days of the date of expiry, the Policy may not be renewed. It is therefore in Your interest to ensure that Your Policy is renewed before expiry.

CAN THE INSURANCE COMPANY REFUSE TO RENEW THE POLICY?

We may refuse to renew the Policy only on rare occasions such as fraud, misrepresentation or suppression or non-cooperation being committed by You or anyone acting on Your behalf in obtaining insurance or subsequently in relation thereto. If We discontinue selling this Policy, it might not be possible to renew this Policy on the same terms and conditions. In such a case You shall however have the option for renewal under any similar Policy being issued by the Company, provided the benefits payable shall be subject to the terms contained in such other Policy.

CAN I MAKE A CLAIM IMMEDIATELY AFTER TAKING A POLICY?

Claims for Illnesses cannot be made during the first thirty days of a fresh Insurance policy. This condition would not apply to those persons who had insurance previously with any insurer and renewing with us on time.

Even for those who insure for the first time, claims for Hospitalisation due to accidents occurring during the first thirty days are payable.

WHAT IS THIRD PARTY ADMINISTRATOR (TPA)?

Third Party Administrator (TPA) is a service provider to facilitate service to You for providing Cashless facility for all hospitalizations that come under the scope of Your policy. The TPA also settles reimbursement claims within the scope of the Policy.

WHAT IS CASHLESS HOSPITALIZATION?

Cashless hospitalization is service provided by the TPA on Our behalf whereby you are not required to settle the hospitalization expenses at the time of discharge from hospital. The settlement is done directly by the TPA on Our behalf. However those expenses which are not admissible under the Policy would not be paid and You would have to pay such inadmissible expenses to the Hospital. Cashless facility is available only in Networked Hospitals. Prior approval is required from the TPA before the patient is admitted into the Networked Hospital. The list of Networked Hospitals can be obtained from the TPA or from their website. You will have full freedom to choose the hospitals from the Networked Hospitals and avail Cashless facility on production of proof of Insurance and Your identity, subject to the claim being admissible. The TPA might not agree to provide Cashless facility at a hospital which is not a Network Hospital. In such cases You may avail treatment at any Hospital of Your choice and seek reimbursement of the claim subject to the terms and conditions of the Policy. In cases where the admissibility of the claim could not be determined with the available documents, even if the treatment is at a Network Hospital, the TPA may refuse to provide Cashless facility. Such refusal may not necessarily mean denial of the claim. You may seek reimbursement of the expenses incurred by producing all relevant documents and the TPA may pay the claim, if it is admissible under the terms and conditions of the Policy.

MY HOSPITAL/DOCTOR IS SUGGESTING ME TO TAKE IMPLANTS/FACILITIES MORE THAN PPN ENABLED CASHLESS FACILITY. WHAT SHOULD I DO?

Cashless facility is offered under Preferred Provider Network of Hospitals to provide Insurance support towards Reasonable Charges as levied by the specific provider and consistent with the prevailing charges taking into account the Nature of Illness/Injury. Additional cost beyond this shall be borne by the Insured.

HAVE TAKEN TREATMENT IN NETWORK HOSPITAL AND DID NOT CLAIM CASHLESS FACILITY. HOW MUCH I WILL GET AS REIMBURSEMENT.

You would be reimbursed Reasonable Charges as levied by the preferred provider under provider and consistent with the prevailing charges taking into account the Nature of Illness/Injury.

CAN I CHANGE HOSPITALS DURING THE COURSE OF MY TREATMENT?

Yes, it is possible to shift to another hospital for reasons of requirement of better medical procedure. However, this will be evaluated by the TPA on the merits of the case and as per policy terms and conditions.

CAN I CHANGE FROM THIS GROUP POLICY TO AN INDIVIDUAL POLICY OF NEW INDIA AT THE TIME OF RENEWAL?

Yes You can. But thereafter, You would be covered by the terms of the Individual Policy, with suitable credit for the years of continuous insurance.

HOW TO GET REIMBURSEMENTS IN CASE OF TREATMENT IN NON-NETWORK HOSPITALS OR DENIAL OF CASHLESS FACILITY?

In case of treatment in a non-Network Hospital, TPA will reimburse You the amount of bills subject to the conditions of the Policy. You must ensure that the Hospital where treatment is taken fulfils the conditions of definition of Hospital in the Policy. Within twenty four hours of Hospitalisation the TPA should be intimated. The following documents in original should be submitted to the TPA within fifteen days from the date of Discharge from the Hospital:

- Claim Form duly filled and signed by the claimant
- Discharge Certificate from the hospital
- All documents pertaining to the illness starting from the date it was first detected i.e. Doctor's consultation reports/history
- Bills, Receipts, Cash Memos from hospital supported by proper prescription
- Receipt and diagnostic test report supported by a note from the attending medical practitioner/surgeon justifying such diagnostics.
- Surgeon's certificate stating the nature of the operation performed and surgeon's bill and receipt
- Attending doctor's / consultant's / specialist's / anaesthetist's bill and receipt, and certificate regarding diagnosis
- Details of previous policies if the details are not already with TPA or any other information needed by the TPA for considering the claim.

HOW TO GET REIMBURSEMENT FOR PRE AND POST HOSPITALIZATION EXPENSES?

- The Policy allows reimbursement of medical expenses incurred before and after admissible Hospitalisation up to a certain number of days. For reimbursement, send all bills in original with supporting documents along with a copy of the discharge summary and a copy of the authorization letter to your TPA. The bills must be sent to the TPA within 7 days from the date of completion of treatment. You must also provide the TPA with additional information and assistance as may be required by the company/TPA in dealing with the claim.

WILL THE ENTIRE AMOUNT OF THE CLAIMED EXPENSES BE PAID?

- The entire amount of the claim is payable, if it is within the Sum Insured and is related with the Hospitalisation as per Policy conditions and is supported by proper documents, except the expenses which are excluded. If the Policy is subject to Loading, then there would be a deduction towards copay.

CAN ANY CLAIM BE REJECTED OR REFUSED?

Yes, a claim, which is not covered under the Policy conditions, can be rejected. In case You are not satisfied by the reasons for rejection, you can represent to Us within 15 days of such denial. If You do

receive a response to Your representation or if You are not satisfied with the response, you may write to our Grievance Cell, the details of which are provided at our website at http://newindia.co.in/public.asp. You may also call our Call Centre at on Toll free number 1800-209-1415, which is available 24x7. You also have the right to represent your case to the Insurance Ombudsman. The contact details of the office of the Insurance Ombudsman could be obtained from http://www.irda.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo234&mid=7.2

WHO SHOULD BE CONTACTED IN CASE I DO NOT RECEIVE MY POLICY?

Policy schedule is being separately mailed to you on email ID given in your application. If you do not receive policy schedule within 24 hours by mail, please write to nia.830000@newindia.co.in, quoting your transaction number. Please do not transact again if payment has been processed.

IS THERE ANY BENEFIT UNDER THE INCOME TAX ACT FOR THE PREMIUM PAID FOR THIS INSURANCE?

Yes. Payments made for health insurance in any mode other than cash are eligible for deduction from taxable income as per Section 80 D of the Income Tax Act, 1961. For details, please refer to the relevant Section of the Income Tax Act.

WHO WILL GET THE CLAIM AMOUNT?

Normally claim amount is transferred in the favour of policy holder. In the event of death of the insured person(s) due to an Insured peril, all benefits payable, in respect thereof under this insurance, shall become payable to the assignee declared in the proposal and the receipt given by the said assignee shall be construed as full and final discharge to the Company in respect of all liability under the policy. Assignee can be anyone other than the proposer.

WHAT COMES UNDER ZONE I, ZONE II AND ZONE III?

Zone I – Anywhere in INDIA

Zone II – Anywhere in INDIA (Except Mumbai and Greater Mumbai)

Zone III – Anywhere in INDIA (Except Mumbai, Greater Mumbai, Delhi and NCR and Bangalore)

Subject to the terms and Conditions of the Policy,

a) Persons paying Zone I premium can avail treatment in any Zone.

b) Persons paying Zone II premium

- Can avail treatment in Zone II and Zone III,
- Availing treatment in Zone I will have to bear 10% of each claim.

c) Persons paying Zone III premium

- Can avail treatment in Zone III
- Availing treatment in Zone II will have to bear 10% of each claim.
- Availing treatment in Zone I will have to bear 20% of each claim.

IS IT MANDATORY TO UPLOAD PHOTOGRAPHS FOR ALL MEMBERS PROPOSED TO BE COVERED UNDER THE POLICY?

Photo uploading is not mandatory, but TPA cashless cards will be issued only if you have uploaded the photos at the time of buying the policy. If you have not uploaded the photo at the time of buying the policy, then you can send the passport size photos in ".jpeg" format (with name of the person against each photo) of all members along with the "policy schedule" received on your mail to following mail id's: contact@mdindia.com, customercare@mdindia.com, icai@mdindia.com, nia.830000@newindia.co.in. You mail subject should be " please issue the TPA cashless cards for policy number ---------- ". Please note that "TPA cash less cards will be issued in 15 working days after receiving your photos and policy schedules by TPA".

WHAT CAN BE THE MAXIMUM COVERAGE / SUM INSURED FOR ANYONE PERSON UNDER THE POLICY?

A person can have maximum up to Rupees 20 Lacs coverage (Sum Insured), under this scheme. This might be under a single policy or may be the combination / sum of more than one policy. Please note that "Maximum coverage for one individual person must be Rupees 20 Lacs or less". If you have more than one policy with coverage for more than Rupees 20 lacs (SUM Insured), you may cancel and get refund for Sum Insured exceeding Rupees 20 lacs.

WHAT I CAN DO, IF I HAVE NOT RECEIVED THE TPA CARD?

If you have uploaded the Photos at the time of buying the policy and not received the TPA cards in 15 working days, then you can download the TPA card directly from the TPA site http://www.mdindiaonline.com using the ICAI login. Here you need to place your policy number to access your TPA cards. Please note that "E- Card downloaded from the TPA website are identical and equally valid as the hard copy, so you can print and keep the same for your reference".

WHAT IS THE DISCOUNT OFFERED FOR NO CLAIM UNDER ICAI TIE UP ?

Discount of 5% on the premium on renewal, in respect of each claim free year, subject to maximum of 20% allowed, provided the policy is renewed under the scheme with the Company without any break. In case, any claim is admitted under the policy, the entire no claim discount earned shall be forfeited on renewal of the said policy. However, the No claim discount shall continue to accrue afresh from the next claim free year.

For example:

1) Present policy with "Nil" No claim discount and with claim free experience will be eligible for 5% discount on renewal premium.

2) Present policy with 5% No claim discount and with claim free experience will be eligible for 10% discount on renewal premium.

3) Present policy with 10% No claim discount and with claim free experience will be eligible for 15% discount on renewal premium.

4) The policy issued with 15% No claim discount will be eligible for 20% No claim discount on renewal, only if the claim experience is "Nil".

IS THERE ANY RESTRICTION ON THE ENTRY AGE IN THE POLICY ?

YES, THE ENTRY AGE IN THE POLICY IS RESTRICTED AT 65 YEARS OF AGE. HOWEVER, THE MEMBER ONCE ENROLLED IN THE POLICY BEFORE TURNING 65 CAN RENEW THE POLICY FOR LIFETIME.

HEALTH CLAIM PROCESS:

M/s. M D INDIA is the assigned Third-Party Administrator (TPA) for servicing of claims under this Scheme. In case of CLAIM, contact M/S M D INDIA TPA. Claim intimation can be sent within 24 hours of hospitalization. Intimation can be given either online at www.mdindiaonline.com or via the Toll-Free Helplines 1800-233-4505 and 1800-233-1166

The Policy holder can log in to M D INDIA portal through the link provided in the ICAI website and inform TPA for planned Operations/ Hospitalisation. TPA will provide guidance and confirmation to network hospital by fax / e-mail & send a text message to you. On getting a Confirmation from TPA, the Policy holder may get admitted for treatment & sign all documents, forms & invoices on discharge. The TPA will make payments to the hospital for pre-approved treatment and as per policy terms & conditions.

Carry Over Credit:

Carry Over credit is the benefit accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break. With Mediclaim Scheme for ICAI, You can carry over Credit for previous continuous Insurance. The Cumulative Bonus earned against any previous insurance policy of any insurer is protected by way of a discount on premium, the details of which are as below:

Cumulative Bonus of upto 10%	5% discount in premium
Cumulative Bonus of 10-30%	10% discount in premium
Cumulative Bonus of above 30%	15% discount in premium

The average Cumulative Bonus available to the family would be considered for the purpose of allowing discount. This Discount is offered as a onetime measure, offered in lieu of Cumulative Bonus offered by the Previous Insurer. This discount would continue to be extended as long as no claim is reported under Policy. For a member with Two Years of Continuous Coverage with any other insurer, pre-existing diseases are covered. To put it shortly, this Policy treats Your previous years of insurance with any insurer, as if You had been insuring with us.

Process for Emergency hospitalization:

Rush the patient to the hospital to avail treatment.

Family to contacts Toll Free No. of TPA or Log in to TPA website.

Authorization for network / non-network hospitals / approval from the TPA can be obtained by submitting required documents.
E.g. Doctor's certificate, etc to the TPA. Hospital bills are directly settled by the TPA.

Important Points:
Cashless service is only available in network hospitals and is subject to the terms and conditions in the policy. You can search for a Network Hospital near You by using the network hospital search tool on the New India website. However, if You choose to go to a hospital outside our network, you will have to pay for the treatment and then re-claim the expenses from us for reimbursement. Contact TPA if You have not received the health insurance cards.
To ensure that Your request for Cashless Authorization is not rejected, send a completely filled pre-authorization Form within the required time frame.
If the TPA does not approve of Your cashless authorization request, , You can still get your claim by paying the bill now and claiming reimbursement later from the TPA.

Re-Imbursement Process:
Claim intimation can be sent within 24 hours of hospitalization. Intimation can be given either online at www.mdindiaonline.com or via the Toll Free Helplines 1800-233-4505 and 1800-233-1166. The policy holder pays the hospital charges in full at the time of discharge. He / She should submit the following documents in originals at the MDIndia Branch mentioned below:
✓ Claim Form duly signed by the insured
✓ Photocopy of ID card
✓ Photocopy of policy schedule (and all previous policies, in case of continuous coverage)
✓ Original discharge card/summary original hospital bills.
✓ For consolidated amounts, a detailed breakup of the amount
✓ All investigation reports and bills in original supported by a note from the attending doctor/surgeon recommending such investigations
✓ Surgeon's certificate stating nature of surgery performed and bill and paid receipt
✓ Certificate from attending doctor/surgeon giving reasons for allowing treatment at home