PAYMENT PROTECTION PACKAGE

Non Health

I. Claims Notification

In the event of discovery of any specified events or circumstances leading to any specified events as defined under the policy

a. The Insured shall notify the Company in writing (with full particulars) of the knowledge of the specified events within the no of days /hours as specified in the Policy

b. The Insured shall give all such information and assistance as the Insurer may require

c. The Insurer shall verify the claim notified in the area of Coverage through various means and shall notify the acceptance/rejection of such claim to the Insured

d. Following reasonable precaution confirmation is required by the Insured to the Insurer:

   a. The Insured has taken due care and reasonable precautions to safeguard their personal information, details of their bank account and/or credit/debit cards and internet communications

   b. Insured has taken all practical measures to minimize the claims

   c. Insured has maintained their personal devices as maintained by the manufacturer or supplier

   d. Insured has maintained and updated internal backups of their data

   e. Insured has maintained and updated their system, device and data security

II. Claims Processing

a) Claim Acknowledgement and Preliminary documents for assessment of loss:

An acknowledgement is sent to the insured along with the claim no. and list of preliminary requirements

Health

A. Claim Intimation & Registration

Claim intimation is the first and foremost step in the claim processing. Typically, there are two types of claim processes, one is cashless and the other is re-imbursement. In case of planned hospitalization (cashless) claim intimation needs to be done prior to hospitalization. In case of emergency hospitalization intimation can be done through network hospitals/insured. In case of re- imbursement claim, intimation to be given along with patient name and claimed amount.

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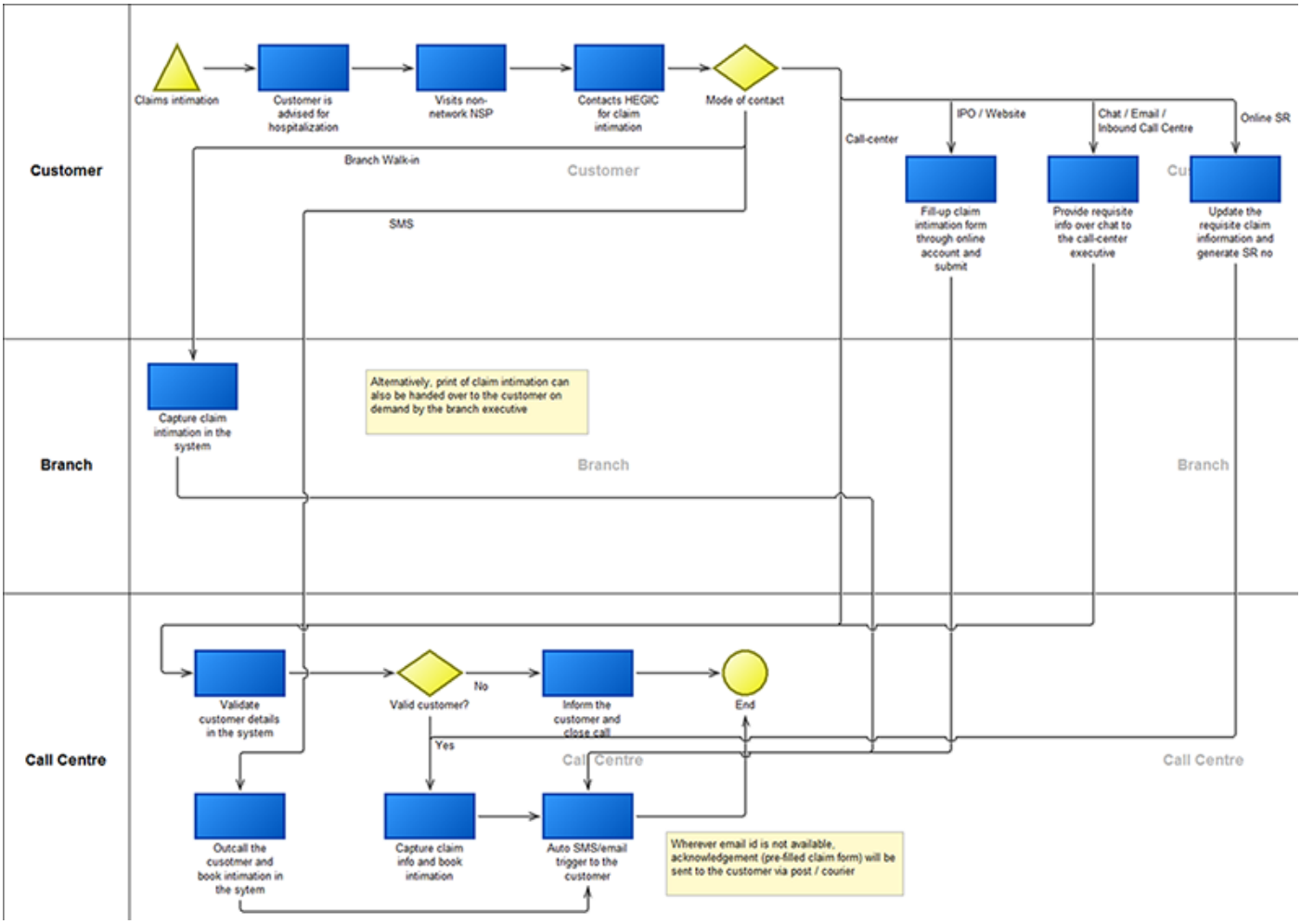
- Customer or network hospitals can get in touch with HDFC ERGO through various options -
  - ✓ IPO (Mobile App)
  - ✓ Inbound Call Centre
  - ✓ Website
  - ✓ Email
  - ✓ Branch Walk in / Submission of Hard Copy
  - ✓ Online Service Request
- In all the aforementioned options, the customer information is verified and then claim is registered in the system
- Post successful registration of claim in the system, an automated SMS and email is sent to the customer mentioning the unique claim control number (CCN)
- In case of branch walk in, the branch executive (BOSG) may handover the print of the claim form to the customer on demand
- For cases where the customer email id is not available, acknowledgement (pre-filled claim form) will be dispatched to the customer via post / courier
- The online claim form is also available in the Help section- “claim registration” of HDFCERGO website.

PAYMENT PROTECTION PACKAGE

Claim Intimation & Registration (High Level workflow)



B) Cashless Claim (Pre authorization) Process other than portal

Sr. no	Activity	Description	Owner
1	Advise for hospitalization	- Insured receives advise for planned / emergency hospitalization for further medical treatment	Medical practitioner
2	Selection of Hospital	- Contacts agent / broker / call-centre/ Website or refer guide book to identify the nearest network hospital, and selects the hospital of his / her choice - On selection of hospital/Nursing home contacts HDFC ERGO / Insurance Desk in the selected hospital/Nursing home and submits / shows the health card	Insured

3	Verification of insured details	- Verifies the HEGIC Health Card and captures the requisite details on the pre-auth form
		- Communicates the same to HDFC ERGO in following ways
		  - NSP Portal
		  - Through fax
		  - Designated HDFC ERGO Email addressfor further medical treatment
			Hospital (Network Service Provider)

PAYMENT PROTECTION PACKAGE

4	Verify and validate insured details	- On receipt of filled-in and signed pre-auth form validates the customer details in system (basis the details mentioned on the pre-auth form). For cases which have the insured details in system, the same is captured in the pre-auth form - In case customer details are not available in system, the details are sent to Operations team for further follow up and resolution	Pre-auth team
5	Registration of claim no	- Once all the required details are captured, generates a claim control number (CCN) which will be triggered to the hospital / insured / intermediary via SMS and email - The claim can also be tracked through web portal/IPO or Call center	System automation
6	Processing of pre-authorization	- After successful registration of claim and updation of all mandatory details in system by 'Pre-Auth' team/NSP vendor through NSP portal, all such cases moves into the work-queue of Medico team - Reviews information and supporting documents processed by 'Pre-Auth' team and takes appropriate decision i.e. - - Approve or - Reject / Deny or - Raise discrepancy / query - Trigger for investigation - All claims submitted by Medico team forms part of the work-queue of QC / Audit team	Medico Team
7	QC and decision	- Reviews information / supporting documents and agrees or disagrees to the decision taken by the Medico team - In case of disagreement updates the remarks and sends such cases back to medico team for onward correction / action - In case pre-auth is approved or denied, automated email, SMS, fax is sent to the network provider as well as to the customer and/ or intermediary - Similarly, cases that have been recommended to be sent to the investigation team falls in the work-queue of the investigation team (Risk and Loss Mitigation Unit) who will carry out investigation and provide their comments to the medico team to either approve / reject a particular claim	QC/ Audit Team
8	Investigation	• System auto triggers/is sent by medico for investigation of health and PA claims from HCS system • As per the recommendation a detailed investigation procedure is carried out by RLMU team and relevant input on the claim given by RLMU. On receipt of RLMU report final decision on claim is taken by HCS	RLMU team
9	Processing of pre-authorization	- Reviews the information and shares decision i.e. approve / decline / raise a discrepancy Rest process will follow as explained above	Medico team

PAYMENT PROTECTION PACKAGE

C. Cashless Claim (Pre authorization) Process through Portal

Sr. no	Activity	Description	Owner
1	Advise for hospitalization	- Advises insured for hospitalization for further medical treatment. - At times emergency / accidents also leads to hospitalization	Medical practitioner / Provider
2	Selection of Hospital	- Contacts agent / broker / call-centre/ Website/ IPO or refer guide book to identify the nearest network hospital, and selects the hospital of his / her choice - On selection of hospital contacts Health Claim Services / Insurance Desk in the selected hospital and submits / shows the health card and valid photo ID proof	Insured
3	Verification of insured details	- Verifies the HEGIC health card through the photo ID proof and accesses HCS Portal to initiate a pre-auth request online - Captures HEGIC card number and additional information wherever required and submits the pre-auth request for approval from HEGIC. - On update of HEGIC card, system helps to auto-fills customer details for valid policies. - On submission, the cases will move to processing pool/directly approved in case of “Nimbu Pani*”.	Hospital (Network Service Provider)
4	Approval of pre-auth request	- Reviews information and supporting documentation updated by ‘NSP’ and takes appropriate decision i.e. ✓ Approve or ✓ Reject / Deny or ✓ Raise discrepancy / query for investigation Rest process will follow as per pre-auth process explained above	Medico Team

The above mentioned process helps to avoid loop from NSP to NM team and NM team to Medico team, and Medico team to QC team.

D. Swift Cashless Approval (*Nimbu Pani Module)

HEGIC Health Claim Services has launched a new innovative platform for ‘Instant Cashless approval’ for its customers. This new solution will allow customers to get instant cashless approvals on health claims across all NSPs.

The solution is designed keeping in mind medical emergencies and thereby ensuring that customer will avail immediate treatment in case of medical exigencies.

It is devised for various treatments and conditions.

Sr. no	Activity	Description	Owner
1	Raise pre-auth request	- Initiates a pre-auth request on HCS Portal for selected medical treatments. - Updates unique reference number to search customer - System will search and validate record for claim which are registered with same NSP/Hospital for the given nature of “medical/ surgical treatments” or conditions. On successful validation, the hospital generates a new claim for the insured/ patient	NSP
2	Approval of pre-auth claim	- On generation of the claim the system validates the set rules fed in the system, to take appropriate decision of approval or denial - Post approval or denial, the communication is sent to the provider as well as customer informing about the same	HCS System
3	Raise of Re-imbursement request	- OSG registers re-imbursement request on HCS system and, processing team verifies whether the treatment/ condition is mapped under the listed conditions as per the set rules in the system	OSG System

PAYMENT PROTECTION PACKAGE

4	Approval of Re-imbursement claim	- On generation of the claim the system validates the set rules fed in the system, to take appropriate decision of approval or denial - Post approval or denial, the communication is sent to the customer informing about the same	HCS System

E. Collection & Scanning

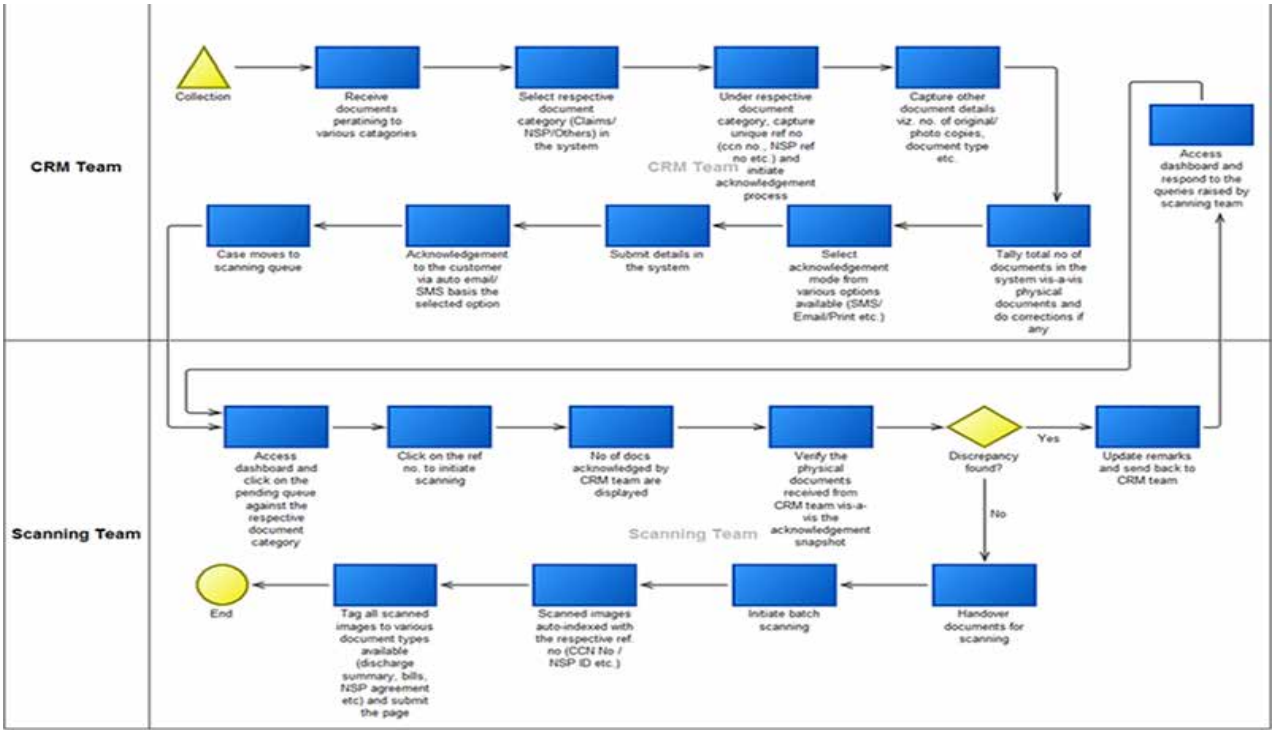
Collection & scanning process involves capturing the soft and the hard copy of documents received as part of different processes.

Sr. no	Activity	Description	Owner
1	Collections	- Receives documents from NSP, courier, walk-in customer or received through e-mail/ Whatsapp communication - In case of BOSG / GEO locations (other than specified locations) provides acknowledgment to customer (walk-in customer) and forwards the documents through courier to specified locations to process it further - Specified locations – Noida, Chennai and Mumbai are the locations where claims documents are being scanned and tagged by dedicated team of Operations (OSG)	OSG / BOSG/ GEO/ CEM
2	Inward the documents in Helios	- Records inward entry for every document received for thorough tracking and record reference - A document could be a single t or multiple in a single packet. Attaches bar codes to every set of document for tracking and records - Post creation of inward, system initiates acknowledgment towards receipt of document to sender of document - All e-mail/ Whatsapp communications are transferred to OSG team for scanning and tagging through Talisma interaction	OSG (Specified locations) / CEM
3	Review & upload of documents	- After reviewing the documents selects appropriate claim type in system i.e. 'Cashless' and 'Reimbursement'. - The list of documents is as follows :- **1. Cashless** a. Preauth request from network hospital duly signed by treating doctor and the insured b. Patient health card copy and/ or photo ID card c. All relevant medical documents and medical bills/ receipts d. KYC form and related documents for claim payments above 1 lakh rupees (not applicable for group policies) e. Other documents as required from case to case basis **2. Reimbursement** a. Claim form b. Patient health card copy and/ or photo ID card c. All relevant medical documents and medical bills/ receipts d. Bank and NEFT details for payment e. KYC form and related documents for claim payments above 1 lakh rupees(not applicable for group policies) f. Other documents as required from case to case basis	OSG (Specified locations) / CEM

PAYMENT PROTECTION PACKAGE

		- Verifies whether claim is already registered in the system - In case claim is not registered, registers a claim in the HCS system for the received document. - Scans the documents and saves it on SFTP folder with specific naming convention i.e. <Claim no>_<Barcode no> - System synchronizes on regular intervals and documents get tagged with respective claim number - Post claim registration and successful tagging of documents in system, documents move to next level in work queue of non medico team	
4	Scanning and storage of orphan documents	- In case user is unable to identify the type of document especially wherein policy no is not available prepares a list of documents along with contact details in excel and shares it with CEM for out-calling. - Mark these documents as 'Orphan' and maintains and shares the data with stakeholders for data circulations. - The documents are uploaded with inwarded barcode folder in HCS and can be viewed by any team - Likewise the buckets are created as per the actions taken by each team. For e.g. 'Send to CEM team, Send to HCS EMP team, Send Back from CEM, Send back from HCS EMP team, Case Rejected etc. - The scanning and tagging team will select one case at a time and assign those particular documents to concern team for eg. if it pertains to Orphan documents same will be assigned to CEM team and if it's NIDB will be assigned to HCS EMP team after updating for it's necessary details of customer and types of documents and necessary details required from CRM team to tag - Upon receiving necessary details from concern team Operations team will proceed to intimate the claim based on the details shared against that case	OSG

Collection and Scanning (High Level Workflow)



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F. Archival & Retrieval

- Post scanning and tagging of the documents, all physical documents are stored with OSG team for 60 days from the claim closure date
- Post 60 days, OSG team forwards the documents to archival vendor i.e. Iron Mountain for archiving
- Physical document sent to vendor will have Claim no., Policy no., Customer Name and Vendor's Barcode fixed. An excel list of documents sent to vendor for storage is maintained by BOSG team along with the Vendor Box numbers
- In case any document is required, details of the documents are searched in the excel list maintained by OSG team on the basis of the Claim number received from the requestor
- The Box barcode number is identified against the claim number and the request for retrieval of physical documents is sent to archival vendor mentioning the claim number details along with the Box barcode no.
- On receipt of the request, vendor sends the requested box to HDFC ERGO within T+2 days(T being the request date to the vendor)
- OSG team receives the box and retrieves the physical documents for the provided claim no. If the request been received from the requestor for the original documents, then the OSG team seeks requisite approval from the National Claims Manager (NCM) for handing over the original document to the requestor
- Upon receipt of the approval, the original claim document is handed over to the requestor and the physical documents in the box is replaced with the approval mail of the National Claims Manager (NCM) along with the photo copy of the original documents. The box is then sent back to Iron Mountain. Details of the documents retrieved from Iron Mountain are updated in the excel list maintained by OSG team

PAYMENT PROTECTION PACKAGE

G. Processing of cashless claims

If an insured is admitted and treated in a network hospital under cashless benefit, the claim is processed and settled directly by us with the hospital.

Sr. no	Activity	Description	Owner
1	Submission of claim documents	- Post the medical treatment / operation, for the purpose of claim settlement, submits the duly filled and signed claim form and other requisite documents to HEGIC through following modes :- ✓ Post / Courier ✓ Branch walk-in ✓ HDFC ERGO Portal ✓ E-mail communication	NSP
2	Verification and acknowledgment of document	- On receipt of claim documents, verifies the customer details basis the claim reference number - Post verification of customer details, update details of the documents received in the system and provide acknowledgement to the customer (in case of walk-ins). - The acknowledgement is also sent to the customer through SMS on mobile number provided by the customer. - After successful updation of documents in the system, hands over the document to the scanning team. The process of handing over documents to the scanning team will be done at set frequency during a day - In the event of delay in claim intimation/ document submissions, the Company's stand to condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the insured	OSG
3	Scanning of documents	- Initiates scanning of all received documents and saves it in predefined order for correct indexing of documents in system. - Saves scanned documents with unique naming convention for auto-tagging of documents with respective claim reference number for correct indexing against document type. - Once the claim documents are scanned and indexed successfully, all such documents will be available in the work-queue of 'Non-Medico Team'	OSG
4	Assigning claim to Non-medico team	- Accesses the work-queue and assigns the claims to a team of non-medico processors	Non Medico Leader
5	Data entry of claim documents	- Accesses his respective processing queue and start working on each claim on same day/ FIFO basis. - Verifies the details as per scanned images tagged to the corresponding claim reference number and insured details as per system. - For correct tagged documents, carries out data-entry of each claim for eg. Claim amount, bill break up, NSP/Doctor/ pharmacy details etc. - Before initiation of data entry of bills, verifies the data processed by OCR (Optical character recognition) tool. OCR tool helps processor to convert virtually any kind of images containing written text (typed or printed) into machine-readable text data - Post verification makes changes wherever applicable and completes data entry for pending supporting bills - Following points are followed while processing the claim document - Hospital final bill amount is considered as claim amount - Unique no is considered as UHID or IPD (Inpatient Dept) or Bill no - Date of admission and discharge is verified to check whether submitted bills are within date of range - Verifies if the tariff rates of NSP are levied correctly. Non-payable details are updated in the system for easy reference for Medico/ QC team - Post successful updation of all details in the system, the claim will move to the work-queue of 'Medico Team Leader'	Non-Medico Processor

6	Assigning claim to Medico Team	- The job of a medico team leader is to access his work-queue and assign claims to Medico team member	Medico Team leader
7	Review and processing of claims	- Evaluates each claim and takes any of the below action:- 1. Approve claim 2. Reject claim 3. Raise discrepancy / query 4. Send for investigation – Claims are triggered both manually and through rule engines (Sherlock and HRE). The manually triggered claim comes through the medico TL. The manually triggered claims are referred for verification once the medico TL agrees 5. Every CIMA closed claim is reviewed by the Medico TLs. Then RLMU team updates the investigation findings to Medico team for review and further processing - Post updation of Medico team's decision, the claims can be approved, denied or query is raised	Medico Team
9	Denial of claims	- If there is discrepancy in the information provided by the provider at the time of seeking cashless approval and at the time of cashless settlement which affects the admissibility of the claim, the cashless claim is denied, and the provider is informed	Claims Team
10	Settlement of claim	- For all approved cases, processes the claim payment through NEFT to the NSP's	Finance Team
11	Closure of Claim	- In case the provider does not resolve the discrepancy / revert to the query raised, within the stipulated timeframe, 3 reminder letters are sent to the provider at set frequency and in case of no revert post 3rd reminder, a closure letter is sent to the provider. If the cashless claim approval is not utilized (basis confirmation received from the NSP), wrongly registered claim by the NSP/ claimant etc will lead to claim closure	Claims Team

H. Processing of reimbursement claims (with & without intimation)

Reimbursement claims can be with or without prior intimation to the HEGIC. The customer/ claimant intimates / informs the insurance company prior to the hospitalization when it's a planned hospitalization. However, in case of an emergency, hospitalization has to be done on urgent basis hence the customer/ claimant does not intimate the insurer in advance. The customer/ claimant can choose from the list of network/ non-network hospitals for his/ her or any of the insured family member's treatment. Below is the process for reimbursement claims-

Sr. no	Activity	Description	Owner
1	Advise for hospitalization	- Advises insured for hospitalization for further medical treatment - At times emergency / accidents also leads to hospitalization	Medical practitioner
2	Selection of Hospital	- Gets in touch with the HEGIC to intimate about the claim. Post successful registration HEGIC provides a unique claim reference number for future reference - Once the patient is discharged from the hospital, for the purpose of claim settlement, gets in touch with HEGIC through any of the below modes – - Through agent / broker - HDFC ERGO Self-help Portal/ IPO (Portal/Mobile) - Through post / courier - Branch walk-in - Through HDFC ERGO relationship manager - Email / In-bound Call-center - If the customer/ claimant contacts it's intermediary, the intermediary collects the requisite claim documents duly filled & signed by the customer and submits them to the nearest HEGIC Branch for onward processing	Customer/ claimant

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3	Verification and acknowledgment of document	- On receipt of claim documents, verifies the customer/ claimant details basis the claim reference number - Post verification of insured details updates details of the documents received in the system and provide acknowledgement to the customer (in case of walk-ins). - However, in case of an emergency where the customer has not intimated about the hospitalization prior to admission in the hospital, captures the requisite claim details and generates a claim reference number - The acknowledgement is also sent to the customer through an auto- email and SMS on the email address and mobile number provided by the customer - After successful updation of documents in the system, hands over the document to the scanning team. The process of handing over documents to the scanning team will be done at set frequency during a day - In the event of delay in claim intimation/ document submissions, the Company's stand to condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the insured	OSG
4	Scanning of documents	- Initiates scanning of all received documents and saves it in predefined order for correct indexing of documents in system. - Saves scanned documents with unique naming convention for auto tagging of documents with respective claim reference number for correct indexing against document type. - Once the claim documents are scanned and indexed successfully, all such documents will be available in the work-queue of 'Non-Medico Team Leader'	OSG
5	Assigning claim to Non-medico team	- Accesses the work-queue and assigns the claims to a team of non medico processors	Non Medico Leader

6	Data entry of claim documents	- Accesses his respective processing queue and start working on each claim on same day/ FIFO basis.
		- Verifies the details as per scanned images tagged to the corresponding claim reference number and insured details as per system.
		- For correct tagged documents, carries out data-entry of each claim for eg. Claim amount, bill break up, NSP/Doctor/ pharmacy details etc.
		- Before initiation of data entry of bills, verifies the data processed by OCR (Optical character recognition) tool. OCR tool helps processor to convert virtually any kind of images containing written text (typed or printed) into machine-readable text data
		- Post verification makes changes wherever applicable and completes data entry for pending supporting bills
		- Following points are followed while processing the claim document
		  - Hospital final bill amount is considered as claim amount
		  - Unique no is considered as UHID or IPD (Inpatient Dept) or Bill no
		  - Date of admission and discharge is verified to check whether submitted bills are within date of range
		  - Verifies if the tariff rates of NSP are levied correctly. Non-payable details are updated in the system for easy reference for Medico/ QC team
		- Post successful updation of all details in the system, the claim will move to the work-queue of 'Medico Team Leader'.
			Non-Medico Processor

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7	Assigning claim to Medico Team	- The job of a medico team leader is to access his work-queue and assign claims to Medico team member	Medico Team leader
8	Review and processing of claims	- Evaluates each claim and takes any of the below action:- - Approve claim - Reject claim - Raise discrepancy / query - Send for investigation - Every CIMA closed claim is reviewed by the Medico TLs. Then RLMU team updates the investigation findings to Medico team for review and further processing - Post updation of Medico team's decision, the claims move to next work queue of 'QC Team'	Medico Team
9	Review and approval of claim	- All claims submitted by Medico/ Non medico team will form part of the work-queue of 'QC Team' - Accesses and reviews claims processed by Medico/ Non medico team and take appropriate decision i.e. agree or disagree to the decision taken by the previous team as follows : - - In case of disagreement, updates the remarks and sends such cases back to concerned team for correction / action - In case of agreement, agrees with the decision taken by the concerned team i.e. all approved claims will move to the finance team for claim settlement - Cases that have been recommended to be sent to the investigation team will fall into the work-queue of the investigation team who will carry out investigation and provide their comments to the medico team to either approve / reject a particular claim - Reviews the claims wherein some discrepancy / query is raised by the Medico/ Non-medico and takes decision i.e. - In case of disagreement, such cases go back to the Medico teams' work queue for corrective action. - In case of disagreement on a particular query for more than 2 times between the Medico team and the QC team, case will be referred to the Medico team leader's work-queue for final decision on the case - After agreement by QC, query is sent to the customer e-mail address by system and incase e-mail is not available such letters (query letters) would be available in HCS with status as 'Pending' for dispatch LCU team accesses HCS to select document type as 'Rejected / Denial' and status as 'Pending' - LCU downloads the PDFs from HCS and changes the status as 'Completed'. The downloaded PDFs are shared with a print vendor for onward dispatch of letter to customer	QC Team
10	Denial of claims	- Reviews the rejected claims and take appropriate action i.e. agree or disagree to the decision. - In case of disagreement, updates remarks and sends such cases back to the Medico/ Non-medico team for onward updating and correction / action. - After agreement by QC, query is sent to customer e-mail address by system and incase e-mail is not available such letters (query letters) would be available in HCS with status as 'Pending' for dispatch - LCU downloads the PDFs from HCS and changes the status as 'Completed'. The downloaded PDFs are shared with a print vendor for onward dispatch of letter to customer	QC Team

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11	Settlement of claim	- For all approved cases, processes the claim payment through NEFT to the customer - Penal interest component for settlement amount, is outlined below - To calculate and pay penal interest amount in HCS & GC system for A&H Claims for Retail LOBs for TAT beyond 30 days, from the last document received date (Bills Received/Query reply received/ Re-open) to the payment date (after payment auditor approval). Incase of investigation of health claims, penal interest will be charged after 45 days - The interest charges are considered as a part of claims payment - Reserve is created of the interest amount calculated and same is reversed post payment to claimant. - The rate of interest is Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due over and above 2% - If the interest amount is above Rs 5000/- TDS is applicable - If the PAN number of the loss payee is not available then 20% deduction on the penal interest amount will be applicable	Finance Team
12	Closure of Claim	- In case the customer does not resolve the discrepancy / revert to the query raised, within the stipulated timeframe, 3 reminder letters will be sent to the customer at set frequency of 15 days and in case of no revert post 3rd reminder, a closure letter will be sent to the customer. - Also the claim withdrawn by the insured/ claimant, wrong claim registered by insured/ claimant, claim intimated but documents not submitted (post appropriate follow up) etc leads to claim closure - Penal interest component is considered for settlement amount, if applicable, as prescribed by IRDA. Please refer IRDA (Protection of Policyholders' Interest) Regulations, 2017 as per Annexure. - LCU team accesses HCS to select appropriate document type and status as 'Pending' - LCU downloads the PDFs from HCS and changes the status as 'Completed'. The downloaded PDFs are shared with a print vendor for onward dispatch of letter to customer - Standard templates used for pre-authorization, settlement letter, rejection letter & reminder letter is included in the annexure	Claims Team

I. Claim processing for Personal Accident

Sr. no	Activity	Description	Owner
1	Processing claim	- On receipt of claim post successful scanning and tagging by Operations/OSG, the claim will flow in work-queue of Non Medico Team. - Verifies the details as per scanned images tagged to the corresponding claim reference number and insured as per system. - For correct tagged documents, carries out data-entry of each claim depending on the product variant - After processing documents will flow to work-queue of 'Medico' and/ or QC depending on the product variant	Non-Medico Processor
2	Review and decision of the claim	- Reviews information and take appropriate decision i.e. approve or reject - If claim rejection due to the Misrepresentation or fraud, goes to the CMO for the final opinion or approval for the rejection - If products cover riders, auto claim generation and document tagging will happen once the main claim is approved	Medico Processor

3	Review and decision of claim	- Checks the decision taken by previous team and transacts further accordingly - Claim will go back to 'Non-Medico' team for correction / re-processing - Rest process will remain as explained above in reimbursement claim processing	QC team

J. NIDB Claim Processing

NIDB (Not in Database) claim processing claim arises in the following scenarios:

1) In case member is new born/ spouse and endorsement is not yet passed for member addition
2) In case new employee joined the corporate and member is not yet added in the system
3) Policy is in existence but not created in the system

Below is the detailed process to be followed in these scenarios:

- On receipt of pre auth request from hospital/insured, Call Center team will search the insured details in HCS system, if not found the request for NIDB cases will be sent to Operations (Ops) team for data confirmation.
- On confirmation, the CRM team registers the claim in NIDB module and auto reserve will be created and the pre auth request will be processed as per the regular procedure
- On receipt of claim documents, the following scenarios can arise:

a) Incase no HEGIC code received with invoices

In this scenario the scanning and tagging team will upload and tag the documents with NIDB claim number and the claim will reflect in the scanning and tagging bucket with status "HEGIC code update pending"

b) Incase HEGIC code received but no invoices received

The claim will reflect in the scanning and tagging bucket with status "Docs pending upload"

c) Incase both HEGIC code and invoices received.

In this scenario, the scanning and tagging team will upload and tag the documents against the system claim number.

The claim will be processed as per the regular procedure

K. Investigation Process

Investigation process can be initiated / triggered in 2 scenarios –

- System based trigger
- Manual trigger

Sr. no	Activity	Description	Owner
1	Initiate investigation for claims	- In case of manual trigger, Medico team reviews information and recommends for investigation. The recommendation has to be agreed by Medico Team leader for triggering it to RLMU team - In case of system based trigger namely Health Rule Engine (HRE)/ Sherlock, system initiates investigation based on the parameters/ claim risk score as given in the annexure. - Such investigation referred cases move to work-queue of Investigation Team.	HCS Medico Team
2	Processing of claim post investigation	- Post detailed investigation process, prepares investigation report prepared by RLMU and push the claim back to the claim system (HCS)	RLMU Team
		- On receipt of investigation report, Medico team takes appropriate action as per observations and collected evidences. In case the fraud is established, the claim is denied under fraud by Medico team, it then goes to CMO bucket for validation. If the claim denial is agreed by CMO, denial communication goes to the customer and auto mail is triggered to BOSG for initiation of policy cancelation without refund - Claims where fraud is not established, follows the normal processing flow explained under "Cashless and Reimbursement " claim processing	

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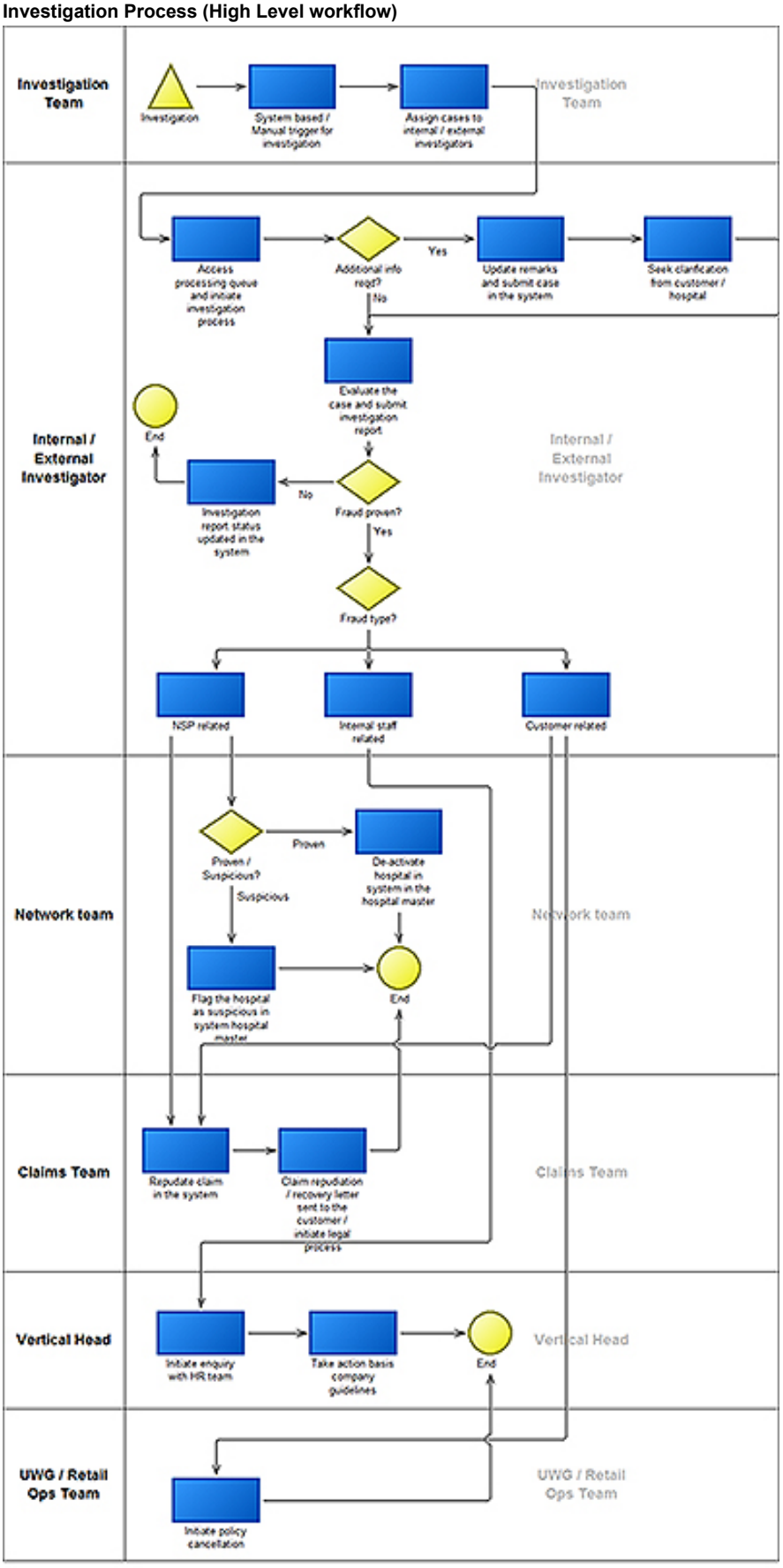
Investigation Process (High Level workflow)



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L. Appointment of external TPA (Third Party Administrator)

All health policies issued post 1st Apr 2012 by HEGIC are services by in house Health Claim Services. At times few corporate insists for external TPA considering their long term relationship with such TPA

Sr. no	Activity	Description	Owner
1	Request of external TPA	- While placing Group Health Business with HEGIC, shows interest to use external TPA (Third Party Administrator)	Corporate client
2	Seek approval for external TPA	- To appoint external TPA, takes necessary approvals from all the designated authorities i.e. HOD Sales, HOD UWG and HOD Claims. - Post approval provides TPA details with operations to share insured data with TPA	Sales Team/ UWG
3	Enrolment of insured data	- Configures a customized health insurance policy, its benefits and terms & conditions for a given corporate	HCS Claim Team
4	Sharing data with TPA	- Post issuance of policy shares insured data with TPA	Retail Operation Group
5	Provide access of system to external TPA	- Gives access for stage wise claim processing file uploader to external TPA to process claims	HEGIC Health Claim Team
6	Processing Claims	- Processes claims on behalf of HEGIC for the client - For high value claims TPA has to take approval from the HEGIC claims team. However, processing payments of claim taken care by HEGIC claims team - For denying a case, the TPA has to take approval from HEGIC claims team - For re-opening of any case, TPA has to take approval from HEGIC claims team - In case of grievance cases, decision has to be taken by HEGIC claims team	External TPA
7	Settlement of claims	- Rest process i.e. approval / denial and settlement of claim will follow normal process as explained in Cashless and Reimbursement process - Responsibility of final approval / denial of claim rests with HEGIC Claim team	HEGIC Claims Team

M. Turnaround time (TAT) for claims process

The turnaround time for the entire claim process is show below:

Cashless Authorization	**Turn Around Time (TAT**
Fresh Request- Planned Hospitalization:	1 hr
Emergency Hospitalization:	1 hr
Deficiency:	1 hr
Reimbursement Claims	
Complete Claim - Settlement:	7 days (30 days from last document received if incase internal verification is required)
Deficiency:	4 days
Deficiency - 1st reminder:	15 days
Deficiency - 2nd reminder:	15 days
Deficiency - 3rd reminder:	15 days
Closure letter:	60th day from the date of first query

Claim settlement TAT as per IRDAI is 30 days from the date of complete document received and 45 days if claim requires an investigation

N. Claim reopen

A claim is reopened due to a list of compulsive necessities at an operational level. The standard list of reason for reopen is embedded in the system. Medico Team leader is authorized to reopen a claim and process further. The standard list of reopen reasons are mentioned below:

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Sr. no	Reopen Reasons	Operational Understanding
1	Reconsideration requests from insured	Must be submitted via appeal process
2	Correction of Diagnosis codes and diagnosis reference	Rectification of ICD, Diagnosis etc
3	Correction of Beneficiary	Beneficiary to be rectified
4	Correction of Service Provider (Hospital)	Change of hospital name
5	Correction of Hospitalization period	DOA/DOD correction
6	Consideration against Award	Must be received from Competent authority
7	Service utilized against closed Pre-auth	Cashless utilized as per letter/proof received
8	Consideration against Consumer Forum Award	Award received from Consumer Forum
9	Underwriting Confirmation against Coverage	Mail received against benefit Covered by Underwriter
10	CIMA Closed case update received	Case acted upon as per RLMU finding and communication
11	Claim assessment correction	Claim reopened to correct the assessment details
12	Reconsideration request from provider	Must be submitted via appeal process from service providers through NSP portal
13	Claim reopened for process post closure of claim	Approval must be received from competent Authority (the Authority being at the level of a CMO onwards)
14	Claim reopened against query closure	Claim which was closed as there was no response from customer initially, post receipt of confirmation on current status
15	Claim to be referred to RLMU	Case to be referred to RLMU on receipt of reconsideration request post repudiation
16	Case acted upon as per RLMU finding	In case where there is an RLMU update basis which case is acted upon from Claims end
17	Claim dependent on assessment of other related claim	In case of Supplementary claims, or Claims referred to RLMU, assessment depends upon the main claim and the claim outcome of RLMU referred cases
18	Claim confirmation on CB	In cases where CB needs to be checked, and updated, clarification received towards the same post which case is acted upon
19	Cashless/AL not utilized	Cashless/AL not utilized
20	Buffer received for further process	In Corporate cases, buffer is issued as per Corporate basis which case is processed further
21	Case acted upon further documentation received from hospital	Case is decided basis documentation submission /or as sent by provider in addition to the initial set of documents(received at the time of initial request)

Note: Once the claim is paid, it cannot be reopened for any reason.

e. Claim Reserving and Payments

The claim reserve for cashless claim is the pre authorization amount and for reimbursement is the total billed claim amount/ Sum insured whichever is lower. The final reserve amount is updated post the claim adjudication.

NEFT rejections:

The claims MIS team to inform the HCS team of NEFT rejections on T+1. The HCS team has to act on the same within 4 days. If any additional details for payment correction are required then query has to be raised with the claimant. Once the query reply is received within two working days the payment needs to be re-issued.

Whenever the claimant requests for the cheque payment a mandate form will be taken from the claimant mentioning the same.

O. Pre-policy Check-up Process

Pre-policy checkup (PPC) is applicable for health proposals where the insured age is above certain limit as prescribed by the insurer for e.g. proposals where the insured age is 45 years and above. Below is the detailed process that is followed in case of PPC proposals –

- All proposals where the insured age is above the prescribed limit will move into the work- queue of in-house HEALTH CLAIM SERVICES call-center
- Call-center executive will outcall such customers to confirm the appointment for PPC in the Diagnostic Center (DC) which is typically within the vicinity of the customer address
- In case customer is not contactable and proposal is tagged as 'Non Contactable', email is triggered to Sales and Customer through system.

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- Basis the email triggered, customer / Sales team provides alternate contact no, for arranging a call for PPC.
- In case alternate contact no is not received within 7 days (from system initiated email), on T+8 days, the data will be shared with the Ops team for onward processing of refund to the customer.
- If the Sales Manager is able to provide the revised contact details of the customer within 7 days (from system initiated email), UWG team will update the latest contact details in the system which will again move into the work-queue of call-center
- Once the customer is contacted, the call-center executive will confirm customer's appointment in the preferred DC. After this step, an auto-intimation is sent to the selected DC
- The DC will then get in touch with the customer and book the timeslot as per customer's convenience
- Customer will visit the DC and complete the medical checkups. Post the medical tests, the DC will update the status and will scan & upload medical reports in the system
- These cases will move into the work-queue of Medico Team Leader who will further assign it to medico processors to evaluate each proposal
- Medico processor will assess each case basis the scanned copies of medical reports and update his remarks / opinion and save the details which will then move into UWG queue
- UWG team will take the final decision on such proposals whether to accept or reject
- For proposals accepted by UWG, operations team will issue policy to the customer and for all rejected cases, operations team will process the refund and dispatch the refund cheque along with the medical reports to the customer

C. Coverage Evaluation:

1. Preliminary documents are scrutinized by the claims team
2. Additional information are requested in case required based on preliminary documents submission
3. Decision on appointment of surveyor/investigator/legal counsel will be taken, if required
4. On receipt of complete claim documents/survey report, claims team will than evaluate the coverage and communicate to the Insured/broker/agent
5. Enhancement of reserves from default to realistic be done based on the review of documents.

D. Payment of the claim:

On receipt of all the documents/information that is relevant and necessary for the claim, the Insurer within period of 30 days shall offer a settlement of the claim to the Insured.

E. Rejection of the claim:

1. If the Insurer, for any reasons to be recorded in writing and communicated to the Insured, decides to reject a claim under the Policy, it shall do so within a period of 30 days from the receipt of the final documents and/or additional information/documents as the case may be.
2. However, expense payments are processed, if any.

F. Claims Reopening

Claims can be re-opened by the claims officer with valid reason for re-opening.

Following is the list of reasons for claim re-opening:

1. Processing of expense payments
2. Submission of documents after closure of claims, on receipt of additional information / documents in support of the claim
3. Re-considering of claim after request from customer through CEM / IRDA /Ombudsman / Consumer forum / Courts etc.

G. Condonation of Delay

The Company may condone delay in claim intimation/ document submission on merit, where it is proved that delay in reporting of claim or submission of claim documents, is due to reasons beyond the control of the Insured.

Notwithstanding the above, delay in claim intimation or submission of claim documents due to reasons beyond the control of the Insured shall not be condoned where such claims would have otherwise been rejected even if reported in time.

H. Penal Interest

In the event the claim is not settled within 30 days from the date of receipt of last relevant and necessary document from the Insured/Claimant, we shall be liable to pay interest at a rate, which is 2% above the bank rate from the date of receipt of last relevant and necessary document from the Insured/Claimant till the date of actual payment.

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I. Claim Documents

Section No	Section Name	Documents required at the time of Claims
All Sections	All Sections	1. Duly completed and signed claim form/details of incident and/or loss 2. Description of the events , in chronological order, as to how, when and where the circumstances leading to the claim or suit occurred 3. Date when the insured became first aware of such complaint/demand/ circumstance 4. Details of the claimants 5. Copies of all written demands / court proceedings initiated against the Insured including the response of the insured to the said demand/ court proceedings 6. Copies of contract copies along with annexures entered between the insured and their clients 7. Details and break-up of the quantum claimed and supporting of the same In case if no quantum is claimed, the estimate of the damages likely to be claimed ; 8. Copies of all relevant communications exchanged between the parties between the claimant and the insured and any agreements entered into; 9. Opinion of the counsel in connection to the merits and demerits of the case 10. Details of other persons or entities which may be responsible or liable for the loss or damage being claimed; and 11. Contact details of Insured's person handling the claim in Insured's company. 12. Copy of FIR/Complaint Copy/Final investigation report 13. Any other document/ information in support of the claim
Section 1	Financial Liability Cover	
	a. Lost or Stolen Card Cover	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim
	h. Fraud Before Delivery of Card Cover	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh Any other document/ information in support of the claim

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	g. Card Forgotten at ATM Cover	h. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events i. Documents stating the date and time the incident took place j. Copy of FIR/Complaint Copy/Final investigation report k. List of any Expenses and/or Loss along with supporting l. All communications exchanged by and with the insured in connection to the incident m. KYC documents for claim settlement when amount is above 1lakh Any other document/ information in support of the claim
	n. ATM Assault Cover	o. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events p. Documents stating the date and time the incident took place q. Copy of FIR/Complaint Copy/Final investigation report r. List of any Expenses and/or Loss along with supporting s. All communications exchanged by and with the insured in connection to the incident t. KYC documents for claim settlement when amount is above 1lakh Any other document/ information in support of the claim
	u. Theft or Robbery Post Withdrawal Cover	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim
	v. Sim Cloning & Deactivation Fraud Cover	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh b. Any other document/ information in support of the claim
	w. Theft of Funds due to Unauthorized Digital Access Cover	In addition to the above, claim documents required for specified events under the policy 1. Message/other communication exchanged between the insured and Bank regarding the unauthorized/theft of fund transaction. 2. Documents indicating that the issuing bank or the digital wallet Company is not reimbursing the insured for the theft of funds, in case your claim amount exceeds a sum of INR 10,000 3. Message /email/other communications received from the perpetrator regarding the transaction 4. Caller Details / Email / Phone number, if any 5. Account details and supporting documents of alleged perpetrator, if any

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		6. Copy of Complaint to Bank / wallet company and Bank's response/Wallet company 7. Details of legal cost incurred in connection to the prosecution of a criminal case against the third party and/or estimated legal cost that will be incurred by the insured until the conclusion of the criminal case 8. Bank statement outlining the prior 3 months transactions 9. Copy of ID proof and address proof as shown in bank record. 10. All communications of the insured with the Bank in case of any penalty levied by the bank 11. All communications/supporting from the insured in connection to lost wages
	x. Identity Theft / Account Take Over Cover	In addition to the above, claim documents required for specified events under the policy a. All communications/supporting from the insured in connection to lost wages b. Particulars of data which has been stolen c. Details of the alleged third party who is responsible for the identify theft. d. Details of demands (if any) arising from the identity theft e. Details of Legal action against/by you
Section 2	Purchase Protection	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim
Section 3	Price Protection	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim
Section 4	Forgery / Counterfeit Cheques Cover	Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim

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Section 5	Cyber Liability	a. Duly completed and signed claim form/details of specified events and/or circumstances leading to specified events b. Documents stating the date and time the incident took place c. Copy of FIR/Complaint Copy/Final investigation report d. List of any Expenses and/or Loss along with supporting e. All communications exchanged by and with the insured in connection to the incident f. KYC documents for claim settlement when amount is above 1lakh g. Any other document/ information in support of the claim
	a. Data Restoration / Malware Decontamination	In addition to the above, claim documents required for specified events under the policy 1. Details of the data that was lost and is required to be restored 2. Details of the IT expert appointed and the rates charged by them /engagement letter 3. Final report of the IT expert along with annexures detailing the complete facts of the incident
	b. Replacement of Hardware	In addition to the above, claim documents required for specified events under the policy 1. Details of the damage that took place and is required to be restored/replaced 2. Details of the IT expert appointed and the rates charged by them /engagement letter 3. Final report of the IT expert along with annexures detailing the complete facts of the incident
	c. Online Shopping	In addition to the above, claim documents required for specified events under the policy 1. Message/other communication received/exchanged between the insured and Bank and/or perpetrator regarding the unauthorized transaction 2. Message /email/other communications exchanged with the perpetrator regarding the transaction 3. Documents indicating the purchase of goods or services which are not delivered or rendered 4. Documents indicating the attempts made by the insured to seek payments or recover the delivered goods
	d. Online Sales	In addition to the above, claim documents required for specified events under the policy 1. Message/other communication received/exchanged between the insured and Bank and/or perpetrator regarding the unauthorized transaction 2. Message /email/other communications exchanged with the perpetrator regarding the transaction 3. Documents indicating the purchase of goods or services which are not delivered or rendered 4. Documents indicating the attempts made by the insured to seek payments or recover the delivered goods
	e. Smart Home Cover	In addition to the above, claim documents required for specified events under the policy 1. Details of the IT expert appointed along with the engagement letter 2. Copy of final report along with annexures of the IT expert

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	f. Cyber Bullying, Cyber Stalking and Loss of Reputation	In addition to the above, claim documents required for specified events under the policy 1. Copy/image of harassment note 2. Email id /phone number or any other means of communication of third party 3. Duration of alleged cyber bullying and nature of the alleged bullying. 4. What are the names of those involved? 5. How have the cyber bullies bullied you, and what have they threatened? 6. Copy of the alleged Email/other communication to evidence the bullying 7. Copy/screenshot of alleged contents/profile of the insured 8. Copies of any legal proceedings with a third party prior 9. Details of alleged third party who is responsible for the damage/loss
	g. Social Media and Media Liability	In addition to the above, claim documents required for specified events under the policy 1. Copy of any demand/complaint legal proceedings made by the Third party against the insured including the response of the Insured 2. Details of the lawyers appointed along with their engagement letters 3. Opinion of the counsel in connection to merits and demerits of the case 4. Details of legal cost incurred by the insured along with supporting and/or estimate of the legal cost to be incurred until the conclusion of the case 5. Copies of all communications exchanged between the Insured and Third Party
	h Network Security Liability	In addition to the above, claim documents required for specified events under the policy 1. Details and documents supporting indicating the breach of data / cyber incident resulting from online activities on the insured's personal device 2. Copy of any demand/complaint legal proceedings made by the Third party against the insured including the response of the Insured 3. Details of the lawyers appointed by the insured along with their engagement letters 4. Opinion of the counsel in connection to merits and demerits of the case 5. Details of legal cost incurred by the insured along with supporting and/or estimate of the legal cost to be incurred until the conclusion of the case 6. Copies of all communications exchanged between the Insured and Third Party
	i. Privacy Breach and Data Breach Liability	In addition to the above, claim documents required for specified events under the policy 1. Details and documents supporting indicating the breach of data / cyber incident resulting from online activities on the insured's personal device 2. Copy of any demand/complaint legal proceedings made by the Third party against the insured including the response of the Insured 3. Details of the lawyers appointed by the insured along with their engagement letters 4. Opinion of the counsel in connection to merits and demerits of the case 5. Details of legal cost incurred by the insured along with supporting and/or estimate of the legal cost to be incurred until the conclusion of the case 6. Copies of all communications exchanged between the Insured and Third Party

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	j. Privacy Breach and Data Breach by Third Party	In addition to the above, claim documents required for specified events under the policy 1. Details and documents supporting indicating the breach of data / cyber incident resulting from online activities on the insured's personal device 2. Copy of any demand/complaint legal proceedings made by the Third party against the insured including the response of the Insured 3. Details of the lawyers appointed by the insured along with their engagement letters 4. Opinion of the counsel in connection to merits and demerits of the case 5. Details of legal cost incurred by the insured along with supporting and/or estimate of the legal cost to be incurred until the conclusion of the case 6. Copies of all communications exchanged between the Insured and Third Party
	k. Liability arising due to Underage Dependent Children	In addition to the above, claim documents required for specified events under the policy 1. Details and documents supporting indicating the breach of data / cyber incident resulting from online activities on the insured's personal device 2. Copy of any demand/complaint legal proceedings made by the Third party against the insured including the response of the Insured 3. Details of the lawyers appointed by the insured along with their engagement letters 4. Opinion of the counsel in connection to merits and demerits of the case 5. Details of legal cost incurred by the insured along with supporting and/or estimate of the legal cost to be incurred until the conclusion of the case 6. Copies of all communications exchanged between the Insured and Third Party
Section 6	Health Cover	
	A. Personal Accident	Death / Disability Certificate
	B. Credit Shield	a. Death / Disability Certificate b. OS Credit Shield statement as on date of loss.
	C. Accidental Hospitalization Expenses	**1. Cashless** a. Pre auth request from network hospital duly signed by treating doctor and the insured b. Patient health card copy and/ or photo ID card c. All relevant medical documents and medical bills/ receipts d. KYC form and related documents for claim payments above 1 lakh rupees (not applicable for group policies) e. Other documents as required from case to case basis **2. Reimbursement** a. Claim form b. Patient health card copy and/ or photo ID card c. All relevant medical documents and medical bills/ receipts d. Bank and NEFT details for payment e. KYC form and related documents for claim payments above 1 lakh rupees(not applicable for group policies) f. Other documents as required from case to case basis
	D. Major Medical Illness	

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Section 7	Group Travel Insurance	
	A. Checked Baggage Loss - Indemnity based	As per Policy Wordings
	B. Baggage Delay – Indemnity based	As per Policy Wordings
	C. Loss of Baggage & Personal Documents - Indemnity based	As per Policy Wordings
	D. Missing of Connecting Flight During Transit - Indemnity Based	As per Policy Wordings
	E. Hijacking	As per Policy Wordings
	F. Flight Delay – Indemnity based	As per Policy Wordings
	G. Emergency Medical Expenses	As per Policy Wordings
	H. Accidental Death	As per I., J. and K
	I. Accidental Death - Air	a. Claim form duly filled b. Copy of the passport /Air tickets copy. c. Post mortem Report or Coroner's Report d. Death Certificate. e. Final police inspection report. f. Bank/Credit card statement indicating buying Air tickets from card. g. KYC form (all mark * are mandatory) and submit self signed KYC documents h. as per checklist mention in form, along with recent passport size photo i. KYC documents for card holder and nominee both(Photo ID & address proof) b. NEFT details of the nominee (Original cancellation cheque printed name mentioned)
	J. Accidental Death - Road	a. Claim form b. Death summary from the hospital. (if card holder admitted to hospital) c. Post-mortem Report d. Death Certificate issued by municipal authorities. e. Medico Legal Certificate copy f. Police FIR copy g. Final Police investigation Report h. Viscera Report if applicable i. Last one year bank Statements prior to date of loss j. Nominee details of the cardholder k. If Nominee not register under card, Then kindly provide legal heir certificate l. Debit/Credit card copy m. Indemnity Bond on the Rs.100 stamp paper. n. Relationship proof of nominee with the cardholder. o. KYC documents for card holder and nominee both(Photo ID & address proof) p. NEFT details of the nominee (Original cancellation cheque printed name mentioned)

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	K. Accidental Death - Rail	a. Claim form b. Death summary from the hospital. (if card holder admitted to hospital) c. Postmortem Report d. Death Certificate issued by municipal authorities. e. Medico Legal Certificate copy f. Police FIR copy g. Final Police investigation Report h. Viscera Report if applicable i. Last one year bank Statements prior to date of loss j. Nominee details of the cardholder k. If Nominee not register under card, Then kindly provide legal heir certificate l. Debit/Credit card copy m. Indemnity Bond on the Rs.100 stamp paper. n. Relationship proof of nominee with the cardholder. o. KYC documents for card holder and nominee both(Photo ID & address proof) p. NEFT details of the nominee (Original cancellation cheque printed name mentioned)
	L. Accidental Death – All Common Carrier	As per I., J. and K.
	M. Key Replacement	As per Policy Wordings
	N. Home Protection Cover	As per Policy Wordings
	O. Hole in One	As per Policy Wordings

j. Contact Details for Claims

Claims Department

HDFC ERGO General Insurance Company Limited

6th Floor Leela Business Park

Andheri Kurla Road, Andheri East

Mumbai-400059

India

Claim can also be notified digitally by sending an email with complete description of loss to: care@hdfcergo.com or a call at 022 – 6234 6234

F Contact Details for Grievance, Ombudsman

In case Insured is not satisfied with the response, wish to lodge the complaint, they may:

- Call our 24X7 Toll free number 022 – 6234 6234 from any Landline & Mobile.
- email us to our customer service desk at grievance@hdfcergo.com

You may also approach the nearest Insurance Ombudsman for resolution, if your grievance is not redressed by the Company. The contact details of Ombudsman offices are mentioned below :

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Names of Ombudsman and Addresses of Ombudsmen Centres

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh

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NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II,Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

PAYMENT PROTECTION PACKAGE

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
OFFICE DETAILS	**JURISDICTION OF OFFICE (UNION TERRITORY, DISTRICT)**
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.