Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2,
One International Center,
Senapati Bapat Marg,
Prabhadevi, Mumbai- 400013
IRDAI Reg. No.150, CIN: U66000MH2010PLC269656

Customer Information Sheet
Description is illustrative and not exhaustive.

SI	Title	Description								
1	Name of the Insurance Product/Policy	**Liberty Health Connect Policy**							NA	
2	Policy Number								NA	
3	Type of Insurance Product/Policy	Indemnity							NA	
4	Sum Insured	Individual/Family Floater policy – Insured 1 Insured 2 Insured 3 Insured 4							NA	
5	Policy Coverage (What the policy covers?)		**Applicable Per Year and Per Insured member in an Individual Sum Insured Policy and for all Insured members combined in a Family Floater Policy. Benefits from 1 to 13 are included within the Basic Sum Insured.**						Part II.D. of the policy	
		Basic SI			**3,4,5, 7.5L**	**2,3,4,5 ,6,7. 5,10L**	**3,4,5,6, 7.5, 10,15L**	**2,3,4,5, 6, 7.5,10, 15 L**	**5, 7.5, 10, 15, 20, 30, 40 L**	
		Sr. No.	**Benefits**	**Description**	**E-Connect**	**Basic**	**Elite**	**Supreme**	**Supreme Plus**	

		1	Hospitalization Expenses							
		a	In-Patient Treatment Expenses	Minimum 24 Hrs hospitalization	√	√	√	√	√	

				as an In-patient						
		b	Day Care Treatment	Medical treatment, and/or surgical procedure undertaken in a hospital/day care centre in less than 24 hours due to Technological advancement.	√	√	√	√	√	
		2	Pre-hospitalisation Expenses	Medical expenses incurred prior to the covered Hospitalization	30 days	60 days	60 days	60 days	90 days	
		3	Post-hospitalisation Expenses	Medical expenses incurred after the covered Hospitalization	60 days	90 days	90 days	90 days	SI upto 10 L: 120 days SI above 10L: 180 days	
		4	Domiciliary Hospitalization Treatment	Home hospitalisation due to nonavailability of hospital bed or because the patient is not in a condition to be moved to a hospital	10% of SI	10% of SI	10% of SI	10% of SI	SI upto 10L: 10% of SI SI above 10L: 20% of SI	
		5	Hospital daily Cash Allowance	Daily cash Per day of hospitalization max up to 10th day of continuous hospitalization. A deductible of first 48 hours of hospitalization is applicable.	Rs.500 /day	Rs.500 /day	Rs.1000 /day	Rs.1000 /day	SI upto 20L: Rs. 2000/day SI above 20L: Rs. 4000/day	

		6	Emergency Local Road Ambulance Charges	Ambulance expenses incurred while transfer the Insured Person to the nearest Hospital (per hospitalization/ included within the basic SI)	Rs.1500	Rs.1500	Rs.2000	Rs.2000	Rs. 5000 per Hospitalization max upto Rs. 15000	
		7	Organ Donor Expenses	Organ donor's screening charges & the medical expenses for an organ donor's treatment for the harvesting of the organ (Included within the Basic SI)	Upto 1 lac	Upto basic SI	Upto basic SI	Upto basic SI	Up to Basic SI	
		8	Second Medical Opinion	Second Medical opinion to augment confidence in the medical diagnosis and treatment plan available once during the Policy period.	√	√	√	√	√	
		9	Recovery Benefit	A lump-sum of Rs. 10, 000 in case of hospitalization for more than 10 days.	NA	NA	NA	√	√	
		10	Nursing Allowance	Payment of Rs.500 as daily allowance up to 30 days per Policy period,	NA	NA	NA	√	√	

				towards						
				engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence						
		11	Restoration of Basic Sum Insured (Injury and Sickness hospitalization both)	100% restoration of basic SI on occurrence of another unrelated event	√	NA	√	√	√	
		12	AYUSH Treatment #	AYUSH treatment refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.	Upto basic SI	Upto basic SI	Upto basic SI	Upto basic SI	Upto basic SI	

				# #Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024.						
		13	Extended policy tenure	Extended policy tenure when out of country for a continuous period of more than 15 days	√	√	√	√	√	
		Optional Covers								
		1	Zero deduct cover	Now get your Non-medical expenses fully paid up to Basic SI without any Deduction	√	√	√	√	√	
		2	Vector Borne Disease Benefit	Get a lump sum amount of INR 5000/member once in a year & up to INR 10000 /family	√	√	√	√	√	

				floater policy Towards treatment of **listed Vector borne diseases diagnosed within the Policy period.						
		3	Super Booster	Get 40% auto increase in Sum Insured for every claim free year up to max. of 150% of Basic SI. With this Booster the total Cumulative Bonus earned for a single Claim free year is 50% of Basic SI.	√	√	√	√	√	
		4	EMI Protector Benefit	Worry free about your EMI's when any of your family member covered in the policy suffering from ***listed Terminal illnesses and/or when is on end of life care treatment. In case of multiple loans of a single member or	NA	NA	Option to select 3 EMI's/5 EMI's within a Policy period maxium up to 50% of Basic SI or 5Lacs whichever is lower	Option to select 3 EMI's/5 EMI's within a Policy period maxium up to 50% of Basic SI or 5Lacs whichever is lower	Option to select 3 EMI's/5 EMI's within a Policy period maxium up to 50% of Basic SI or 5Lacs whichever is lower	
				multiple members of a family insured under the policy having Loans the sum						

				of all EMI amount will be payable up to selected no. of EMI's and/or outstanding Number of EMI's and/or Actual outstanding Loan amount whichever is lesser. Waiting period of 90 days from inception of this Policy will be applicable. The cover will get ceased once the claim is accepted and paid. You may still renew the Policy with this cover excluding the claimed member.						
		5	PED Protector	~~Reduce the~~ ~~Long Waiting~~ ~~period~~ ~~applicable for Diabetes & Hypertension and its consequences to 2 / 1 Policy year.~~ ~~Entry age: 50 years and below can opt~~	~~2~~ ~~compl~~ ~~ete~~ ~~Policy Year: PED limited to 30% of SI or max~~ ~~upto INR 1 Lacs~~	2 compl ete Policy Year: PED limited to 30% of SI or max upto INR 1 Lac	2 comple te Policy Year: PED limited to 30% of SI or max upto INR 2 Lacs	1 comple te Policy Year: PED limited to 30% of SI or max upto INR 2 Lacs	1 complete Policy Year: PED limited to 30% of SI or max upto INR 2 Lacs whichever is lesser 2 complete Policy Years: up to Basic SI	

				~~for this Optional cover~~NA	~~whichever is lesser 3 complete Policy Years: PED limite dup to Basic SI~~ NA	whichever is lesser 3 complete Policy Years: PED limite up to Basic SI	whichever is lesser 3 complete Policy Years: upto basic SI	whichever is lesser 2 complete Policy Years: up to Basic SI		
		6	Global Cover	Coverage for emergency care Medical Expenses incurred outside India limited upto 50% of Basic Sum Insured	NA	NA	NA	NA	√	

		7	Domestic Travel Plus	Covers In-patient Hospitalization up to 2X of Basic SI for an injury arising due to Accidental event of a Common carrier in which the Insured is travelling as a fare paying passenger provided the accidental event is > 150 kms away from the residential address as mentioned in the Policy Schedule. The service will be offered on cashless mode.	NA	NA	NA	√	√	
		8	Reload of Sum Insured	By opting this cover, Restored Sum Insured under Restoration cover can be utilized for same illness.	√	NA	√	√	√	
		9	Co-Pay	Get equivalent % of Discount as you opt Co-pay per claim: 5% , 10% , 20%	√	√	√	√	√	
		10	Modern Surgeries limit	Get Discount on premium by selecting limit up to 50% of SI for 12 *listed Modern treatments.	√	√	√	√	√	

		11	Room Rent limit	Opt Room rent limit of 1% of Basic SI or maximum up to INR 5000/day and get discount on premium	√	√	√	√	√	
		12	Cataract Capping	1. Cataract per eye limit: 3 to 4L SI - 25K per person 5 to 7.5L SI -	√	√	√	√	√	
				35K per person 10L & above - 40K per person 10 n above - 50K per person/Yr. max 75K						
		13	Complete Insurance Package Discount	Avail discount of 1% per active policy with Liberty's Motor Insurance Policy, Critical Connect policy, Individual Personal Accident Policy & Health Connect Supra Policy	√	√	√	√	√	
		14	5% discount for Female proposer	Avail discount of 5% for Female proposer	√	√	√	√	√	

		15	Direct /Employee Discount	Direct discount of 10% if policy purchased from Company's web-portal or if an Insured is a employee of the Company	√	√	√	√	√
		16	Premium payment	Annual/ Half-yearly, Quarterly, Monthly	√	√	√	√	√
		17	Extended policy tenure	Extended policy tenure when out of country for a continuous period of more than 15 days	√	√	√	√	√
		Renewal Features							

		18	Renewal Health Check Up	Cashless Health Check up after a block of 2 Renewals with Us (irrespective of Claims History)	√	√	√	√	√	
		19	Loyalty Perk/ Discount in Renewal Premium	Auto increase in Sum Insured by 10% on basic sum insured for every claim free year up to max. of 100% of SI Or • Discount in Renewal Premium: As per the choice/ express consent of the Insured Person at the time of every renewal Insured has choice to choose Discount in renewal premium in the in lieu of auto increase in Basic Sum Insured (Loyalty Perk /Cumulative Bonus) for every claim free Policy year	√	√	√	√	√	
		20	Basic Sum Insured Enhancement/Change in Plan	Enhancement in Sum Insured/ Change in Plan can be done at renewal of the policy subject to approval by the Company.	√	√	√	√	√	
		Waiting Period								

		1	30 days Exclusion	Yes	√	√	√	√	√	
		2	12 months Exclusion	Yes	√	√	√	√	√	
		3	24 months Exclusion	Yes	√	√	√	√	√	
		4	Pre-existing Diseases Waiting Period	Policy will cover the Pre - existing diseases after a waiting period Of	36 months	36 months	36 months	24 months	24 months	

6	Exclusions (What the policy does not cover)	**i. Standard Exclusions:-** **1. Pre- Existing Diseases –** . "Pre-existing disease (PED)" means any condition, ailment, injury or disease: . a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or . b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy. c) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase. d. If the Insured person is continuously covered without any break as defined under the Portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to be extent of prior coverage. e. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-exiting Disease is subject to the same being declared at the time of application and accepted by the Insurer. **2. Specified disease/procedure waiting period-** a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of below mentioned months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident. b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply. d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion. e) If the Insured Person is continuously covered without any break as defined under the applicable norms on Portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.		Part IV.E.i. of the policy Part IV.E.i.1 of the policy Part IV.E.i.2 of the policy

		3. 30-day waiting period- a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered. b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.		Part IV.E.i.3 of the policy
		4. Investigation & Evaluation – a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded. b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.		Part IV.E.i.4 of the policy
		5. Rest Cure, rehabilitation and respite care- Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes: i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.		Part IV.E.i.5 of the policy
		6. Obesity/ Weight Control: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: 1) Surgery to be conducted is upon the advice of the Doctor 2) The surgery/Procedure conducted should be supported by clinical protocols 3) The member has to be 18 years of age or older and 4) Body Mass Index (BMI); a) greater than or equal to 40 or b) greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss: i. Obesity-related cardiomyopathy ii. Coronary heart disease iii. Severe Sleep Apnea iv. Uncontrolled Type 2 Diabetes		Part IV.E.i.6 of the policy

		7. Change-of-Gender treatments: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **8. Cosmetic or plastic Surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner. **9. Hazardous or Adventure sports:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. **10. Breach of law:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. **11. Excluded Providers :** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.		Part IV.E.i.7 of the policy Part IV.E.i.8 of the policy Part IV.E.i.9 of the policy Part IV.E.i.10 of the policy Part IV.E.i.11 of the policy

		12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **13.** Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **14.** Dietary supplements and substances that can be purchased without prescription including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **15. Refractive error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **16. Unproven Treatments:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. **17. Sterility and Infertility:** Expenses related to sterility and infertility. This includes: (i) Any type of contraception, sterilization (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI (iii) Gestational Surrogacy (iv) Reversal of sterilization		Part IV.E.i.12 of the policy Part IV.E.i.13 of the policy Part IV.E.i.14 of the policy Part IV.E.i.15 of the policy Part IV.E.i.16 of the policy Part IV.E.i.17 of the policy

		18. Maternity: ii. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; iii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period. **ii. Specific Exclusions -** 1. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & Trichomoniasis, Human T Cell Lymphotropic Virus Type III (HTLV-III or IITLBIII) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind. 2. Any dental treatment or surgery unless requiring hospitalization arising out of an accident. 3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication. 4. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment. 5. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants. 6. External Congenital Anomaly. 7. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.		Part IV.E.i.18 of the policy Part IV.E.ii. of the policy

		8. Exclusions specific to AYUSH Treatment The Company shall not make payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following: • OPD / Day care treatment • Wellness and non-therapeutic treatment • Any Pre-Hospitalization and Post-Hospitalization Expenses • All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary. • Non- Prescribed medicines by treating physician, non-disclosed formulations & non-standardized preparations or Health Supplementary products will be excluded. • Any Pre or Post hospitalization AYUSH treatment taken before/pursuant to inpatient Allopathy treatment. The above exclusions are in additions to the General exclusions listed under the Policy. 9. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy. 10. Treatment received outside India. 11. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds. 12. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens. 13. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness. 14. Personal comfort and convenience items or services including but not limited to TV(wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies. 15. Expenses related to any kind of RMO charges, service charge,	Part IV.E.ii. of the policy	

		surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head. 16. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion: a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death. b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death. c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and /or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death. In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded. 17. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products. 18. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.		
7	Waiting period	* Pre-existing Diseases will be covered after a waiting period of 36/24 months as per plan opted. * Specified surgeries/treatments/diseases are covered after specific waiting period of 12 months. * Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months * Specified surgeries/treatments/diseases are covered after specific waiting period of 36 months * Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident.		Part IV.E.1 Part IV.E.2 Part IV.E.2 Part IV.E.2 Part IV.E.3

8	**I. Sub-limit** (It is pre-defined limit, and the insurance company will not pay any amount in excess of this limit)	**Sub-limit** - Sub-Limit is not applicable in this product.		Benefit Schedule & Annexure of the Policy
	II. Co-Payment (It is a specified amount/percentage of the admissible claim amount to be paid by policyholder/insured).	Co-Payment - Co-Payment is not applicable in this product.		
	III. Deductible (It i specified amount – up to which an insurance compar will not pay any cl and which will be deducted from to claim amount (if c amount is more t the specified amo	Deductible - A deductible of first 48 hours of hospitalization is applicable to Hospital Daily Cash Allowance and Nursing Allowance.		
	IV. Any other limit (as applicable)	NA		

9	Claims/Claims procedure	**a. For Cashless Service:** You may call to our Customer care number for obtaining Cashless facility. You may also visit to our Company website www.libertyinsurance.in to know the list of empaneled Hospitals. **b. For Reimbursement of Claim:** You need to intimate Us immediately on hospitalization/ injury/ death, further submit all claim documents with supporting details/documents at your own expense to the TPA within 15 days of discharge from the hospital. **Turn Around Time (TAT)** for claim settlement: * TAT for preauthorization of cashless facility within 2 Hours. * TAT for cashless final bill authorization within 2 Hours. Link to be provided below for the said details - i. Network Hospital details – https://www.libertyinsurance.in/products/CPMigration/hospitalLocator ii. Helpline number – 1800 266 5844 iii. Claim form – https://www.libertyinsurance.in/customer-support/download-forms.html **Claim Procedure** **a. Notification of claim:** Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below: i. Policy Number / Health Card No ii. Name of the Insured / Insured Person availing treatment iii. Details of the disease/illness/injury iv. Name and address of the Hospital v. Any other relevant information Intimation must be given at least 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre – Post		Part V.G.5 of the policy

		Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier. The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured Person/s. The Insured Person/s shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. The Company shall settle claims, including its rejection, within thirty working days of receipt of the last required documents. **b. For opting Cashless Facility:** (applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission. i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider. ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner. iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation. iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital. v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.		

		c. Reimbursement Claims - Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital should be given to Us immediately on hospitalization /injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 15 days of discharge from the hospital the following: i. Claim form duly completed in all respects ii. Original Bills, Receipt and Discharge certificate / card from the Hospital. iii. Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions. iv. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests. v. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt. vi. Attending Doctor's / Consultant's / Specialist's / - Anesthetist's original bill and receipt, and certificate regarding diagnosis. vii. Medical Case History / Summary. viii. Original bills & receipts for claiming Ambulance Charges ix. Any additional documents or information, as may be deemed necessary by the Company or TPA. The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company. The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. Applicable Taxes prevailing at the time of claim will be		

		considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Basic Sum Insured opted. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy. **CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM** Ø **In-patient Treatment /Day Care Procedures** q Duly filled and signed Claim Form. q Photocopy of ID card / Photocopy of current year policy. q Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no. and break up of each Item, duly signed by the Insured. q Original payment Receipt of the hospital bill with receipt number q First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from attending Medical Practitioner / Surgeon demanding such test. q Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts q Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same q Original medicine bills and receipts with corresponding Prescriptions. q Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts. q Hospital Registration Number and PAN details from the Hospital q Doctors registration Number and Qualification from the doctor. Ø **Road Traffic Accident** In addition to the In-patient Treatment documents: q Copy of the First Information Report from Police Department / Copy of the MedicoLegal Certificate. <u>In Non Medico legal cases</u> q Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained) <u>In Accidental Death cases</u> q Copy of Post Mortem Report (if conducted) & Death Certificate Ø **For Death Cases** In addition to the In-patient Treatment documents: q Original Death Summary from the hospital.		

		q Copy of the Death certificate from treating doctor or the hospital authority. q Copy of the Legal heir certificate, if the claim is for the death of the principle insured. Ø **Pre and Post-hospitalisation expenses** q Duly filled and signed Claim Form. q Photocopy of ID card / Photocopy of current year policy. q Original Medicine bills, original payment receipt with prescriptions. q Original Investigations bills, original payment receipt with prescriptions and report. q Original Consultation bills, original payment receipt with prescription. q Copy of the Discharge Summary of the main claim. Ø **Ambulance Benefit** q Duly filled and signed Claim Form. q Photocopy of ID card / Photocopy of current year policy. q Original Bill with Original Payment Receipt. q Treating Doctor's consultation prescription indicating Emergency Hospitalization. Ø **Reimbursement of Organ Donor Expenses** In addition to the documents of general hospitalization q Organ Function test / blood test proving organ failure. q Treatment Certificate issued by the Transplant Surgeon of the hospital concerned. Ø **Hospital Cash Allowance** Same as In-patient Hospitalisation treatment Ø **Restoration of Basic Sum Insured** Same as In-patient Hospitalisation treatment Ø **Recovery Benefit** Same as In-patient Hospitalisation treatment Ø **Nursing Allowance** In addition to the In-patient Treatment documents: q Duly signed prescription for Private Nursing requirement and its necessity from the treating Medical Practitioner. q Original Bill with Original Payment Receipt of Nursing charges from the utilized Nursing Burrow/Private Nurse. Ø **Extended Policy Tenure** q Proof of travel outside the Country specifying a period more		

		than 15 days consecutively. Ø **Tele-medicine** q A proper invoice or numbered bill of consultation with date q A proof of payment either a Online, G-PAY or Pay-TM q The consultation note or Prescription with Physicians registration number and details q All investigation report advised with bills and prescription We may call for additional documents/ information as relevant to the claim. **Applicable to all claims under the Policy:** a. In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider. b. If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense. c. If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses. d. The Policy - excludes the Standard List of excluded items - attached in the Policy document. e. We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions or reject the claim as per the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document. f. All claims will be settled in accordance with relevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time. g. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.		

10	**Policy Servicing**	**Step - 1** Call center number - 1800-266-5844 (8:00 AM to 8:00 PM, 7 days of the week) or Email us at: care@libertyinsurance.in Senior Citizens can email us at - seniorcitizen@libertyinsurance.in or Write to us at: Customer Service Liberty General Insurance Limited, 10th Floor, Tower A, Peninsula, Business Park, Ganpatrao Kadam, Marg, Lower Parel, Mumbai 400 013. **Step - 2** If our response or resolution does not meet your expectations, you can escalate at - Manager@libertyinsurance.in **Step - 3** If you are still not satisfied with the resolution provided, you can further escalate at - ServiceHead@libertyinsurance.in		Part V.F.15 of the policy
11	Grievances/Complaints	IRDAI Integrated Grievance Management System - https://igms.irda.gov.in Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.		Annexure-B

12	Things to remember	**Free Look Cancellation:** The insured person shall be allowed free look period of 30 days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. The Free Look Period shall be applicable only for new individual health insurance policies, except for those policies with tenure of less than a year and not on renewals. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to - i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; **Policy Renewal:** : The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person. i. The Company shall give notice for renewal atleast 30 days prior to expiry of the policy. ii. Renewal of a health insurance policy shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy. iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period. iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.		Part V.F.i.14 of the policy Part V.F.i.10 of the policy

		Migration and Portability: The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for Migration of the policy atleast 30 days before the policy renewal date as per the IRDA Guidelines on Migration. If such person is presently covered and has been continuously covered without any lapse under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDA Guidelines on Migration. The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. **Change in Sum Insured:** Basic Sum Insured can be enhanced only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and with the specific approval and acceptance by the Company. In all such case of increase in the Basic Sum Insured, waiting period will apply afresh in relation to the amount by which the Basic Sum Insured has been enhanced.		Part V.F.i.8& 9 of the policy Part iii.15 of the policy
		Moratorium Period: After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract. Note: The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period. The policies would however be subject to all limits, sub limits,		Part V.F.i.12 of the policy

		co-payments, deductibles as per the policy contract.		
13	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.		Part V.F. i. 1 & 2

Declaration by the Policy Holder:

I have read the above and confirm having noted the details:

Place:

Date: (Signature of the Policy)

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