The other day, I was in a branch of the LIC and overheard a LIC agent talking to her senior. She was talking about a mediclaim policy that LIC is offering. The main theme of the talk was that one of her customers was interested in the policy but he was reluctant to buy because he would not get any money back and to top it all, in case of death, he would get nothing at all! Whereas there was some other policy that would pay out returns, so why should he or anyone buy this particular policy? Her senior, surprisingly, agreed with her!

This point of view has resulted in very few people really buying Medical insurance in India – to their own peril.

A mediclaim is a MUST – in fact, everyone should be covered by Mediclaim policy from birth to death. So, if you do not have a policy for yourself, your kids or your parents, now is the time to take one. This is the first insurance policy that one should take – before ANY other insurance or investment.

Mediclaims are broadly divided into two types – the ‘event triggered’ and the ‘reimbursement’ type.

In case of an ‘event triggered’ type of policy, certain major illnesses are covered and as soon as medical evidence is produced that the person has got that illness, the amount insured for is paid out – irrespective of the cost of treatment or even if the insured person goes in for any treatment at all! There are various variations to this policy.

The ‘reimbursement’ type of policy is the most common form of Mediclaim prevalent. In this case, one has to get admitted to a hospital and then gets reimbursed for the expenses involved, subject to certain limits. There are two major variations for the policy:

- **The normal one**

  In this case, the insured has to pay all costs himself and has to submit all the bills and paperwork after discharge for reimbursement.

- **Cashless**

  In this case, the insurer will have given a list of ‘approved’ hospitals and one has only to show his mediclaim card at these hospitals at the time of admission and after that the hospital will directly liaise with the insurer to recover the charges.

  However, things are not as straightforward – somehow they never are!

  To administer claims, the insurance companies appoint what is called a ‘TPA’ (Third Party Administrator). All claims are actually submitted to a TPA who goes through it and carries out any enquiries or investigations before passing the claim. It is obvious that their job is primarily to find reasons to reject the claim outright or if that is not possible, to reduce the amount of the claims as much as possible.

  So, in the case of a cashless policy, the hospital submits the claim to the TPA, who routinely reduce the amount claimed and delay payment on one pretext or the other. So, to cover this risk, the hospitals routinely jack up the bills. Unfortunately, it is money paid out against your policy, so your premiums will go up next time or a lesser amount will be available to claim for the rest of the year.

  It is my view that if possible, one should pay and settle the bills in the hospital, irrespective of the availability of the cashless option and then claim from the insurer.
Some very important points

· If your employer covers you for medical costs, find out the following:
  
  o The amount of the cover
  
  o Are you covered on leave
  
  o Is your family covered
  
  o For how many days between contracts are you covered

  If you are covered for too little an amount or are not covered on leave or your family is not covered, it is most prudent to buy additional medical insurance.

· In case of being admitted to a hospital, the insurance company has to be informed within 24 hours of being admitted. The most common reason for rejection of a claim is that this condition was not complied with – even if the person himself COULD NOT have reasonably informed the company within that time – eg being in a coma or in the ICU. Of course, if one goes to the consumer forum, the claim will definitely be upheld, but then how many of us will actually take that step? So, find out the person and the phone number where this information has to be given and prominently display it somewhere at home. In fact, following up with an email would be even better as it will serve as a proof of intimation. Let all the family members know this.

· Another major reason for rejection of claim is ‘giving false information’ at the time of taking the policy – say concealing the fact that one is a smoker or that one has hypertension. Normally, pre existing diseases are covered after 3 – 4 years, however, if they are not declared at the time of applying for the policy, the claim is liable to be rejected.

· Do NOT let the agent fill up the form – asking you only to sign a blank form. He gets his commission only if the policy is issued, so if there is a slight chance that the policy may be rejected, he will conceal the facts – which will only show up adversely at the time of claims.

· Keep things simple – study the policy carefully for a couple of hours – remember that when the claims would be made you would most probably be in hospital or recuperating and the wife would be running around for the claim. So, go in for a policy that does not have too many complications.

· Keep a stash of emergency money – about Rs 2 to 3 lacs at least and let the family know where it is and how to access it, as most hospitals would ask for a large deposit up front and then constant payments every day. This stash should preferably be available by credit card or a debit card – most hospitals will insist on cash payments. In a recent case that I was involved in, the
person was admitted to ICU and almost Rs 2 lacs had to be paid on the 2\textsuperscript{nd} day itself! Of course, the hospital did not insist on the payments immediately, but it was a worry.

- The TPA will ask for the death certificate or the discharge certificate along with attested copies of what is called the ‘indoor case paper’ – this are documents where the attending doctors, specialists and nurses make their notes. It is extremely crucial (for a claim) that someone monitors what is written in these documents. Let me give an example – say the doctor finds the blood pressure too high and writes ‘hyper tension’ in his notes, the TPA may ask you to give proof of when this hyper tension was detected – if you cannot, then there is a possibility that the claim will be rejected for concealing facts – stating that this was detected before the policy was issued but not disclosed. So, if at all the doctor has to mention hypertension in the notes – he should write it as ‘hypertension – no previous record of it’ or something like that. So, it is essential to go through the records on a daily basis – though the hospitals hate showing you the records because one generally tends to raise various queries and take up their time.

By the way – the LIC agent I mentioned at the beginning – I explained to her to make sure that she sells this policy to all her customers and convince them to consider the premium paid as ‘donation’ to the insurance company. I pointed out that if something happens to the main bread earner of the family – it may be necessary to sell off ornaments or other assets to pay of the medical bills – this was a policy against that happening. Also, I told her that this was one policy that all her customers should pray that they never have to take advantage of!

Lastly, let me end this with two points

- If you truly love your family and close ones, the best gift you can give them is to take care of your health.

- It is really stupid to slog 12 – 15 hours a day in an office only to hand over the hard earned money to the doctors.

Happy investing
Niranjan Bangera
Director
36 Properties Pvt Ltd
info@36prop.com
09870215520