EMPLOYEE INSURANCE POLICY

- Group Mediclaim Policy
- Group Personal Accident Insurance Policy

Policy effective 7th December’12
**Objective**

To support employees in their immediate and long term needs by providing various kinds of healthcare and accident coverage.

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**GROUP MEDICLAIM POLICY**

**Scope**

All confirmed employees of the Phoenix Group, who are not covered under Employees’ State Insurance Scheme of India.

**Policy Details**

**General Guidelines**

1. The policy is being provided by an Insurance Company (currently ICICI Lombard I Healthcare) and administered by the Corporate HR Department, and the amount of premium is borne by the company.

2. At the time of claim (reimbursement or cashless), the company shall bear 50% of the actual claim (subject to the max coverage allowed as mentioned in point no.9) and the balance 50% will be borne by the employee.

3. Only Female employees working with the company shall be eligible for Maternity claim under the policy. For confirmed employees, there shall be 9-month waiting period to avail of Maternity Benefits. This means any female employee should have completed 9 months after being enrolled for the insurance cover.

4. In case of maternity claim the cap on normal cases would be to a maximum of Rs.25000/- and for C-Section the same would to a maximum of Rs.50000/-. 

5. The Group Mediclaim Policy shall cover all the eligible employees, along with their spouse and children (maximum two children) up to the age of 21 years.

6. In case of any change in marital/family status of an employee, it is the responsibility of the employee to inform the HR Department at the earliest in the prescribed manner.

7. Members can avail of cashless facility under this policy; For this purpose they shall be issued a UH ID number, which can be used at the networked hospitals.

8. All other conditions applicable for benefits shall be as per the regulations of the Insurance Company.
9. The amount of coverage in different grades shall be as given below:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Maximum Coverage (Including self, spouse and maximum two children)</th>
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</thead>
<tbody>
<tr>
<td>M1 – M2</td>
<td>Rs 5,00,000/-</td>
</tr>
<tr>
<td>M3 – M5</td>
<td>Rs 3,00,000/-</td>
</tr>
<tr>
<td>E1 – E5</td>
<td>Rs 2,00,000/-</td>
</tr>
<tr>
<td>S1 – S3</td>
<td>Rs 1,50,000/-</td>
</tr>
</tbody>
</table>

**Process Details**

(A) **Process for Network Hospitals**: This policy provides for cashless cover at all ICICI Lombard Network Hospital.

1. The Insurance Company (ICICI Lombard I – Health Care) shall issue UH ID numbers to each and every beneficiary, along with a list of network hospitals.
2. If the employee chooses to get admitted in an ICICI Lombard Network Hospital, he/she shall be required to obtain a doctor’s reference letter and submit the same to ICICI Lombard I – Health Care.
3. The doctor’s reference letter is required to be in the prescribed format (available in the Beneficiary Guide Book or can be downloaded from the website: www.icicilombard.com).
4. On receipt of the form, the doctor at ICICI Lombard I – Health Care shall verify an employee’s coverage vis-à-vis the insurance policy, and send an authorization letter to the employee’s hospital.
5. The beneficiary shall have to produce the UH ID number and Pre-Authorization Letter to the network hospital for availing admission and cashless treatment (List of hospitals shall be as given by the insurance company).
6. In case of an accident or medical emergency, the employee is advised to get admitted according to the hospital norms and is required to intimate ICICI Lombard I – Health Care within 24 hours of admission; ICICI Lombard I – Health Care shall verify the employee’s coverage and accordingly issue the authorization letter to the network hospital.
7. The hospital shall discharge the employee’s payment of bills on the basis of the authorization letter.
8. In case the bill exceeds the authorization amount, the employee shall be required to pay such amount to the hospital himself/herself.
9. For any queries regarding the above facility, ICICI Lombard I – Health Care can be contacted at their Helpline number 1800-209-8888 or ihealthcare@icicilombard.com.
(B) Process for Non-Network Hospitals: The employee shall have to pay for all the hospital expenses and submit all relevant documents to the HR Department within a month from discharge.

1. The following documents are required to be submitted within 1 month of discharge from the hospital for claiming the reimbursement:
   - Claim Form;
   - Hospital Bill/ Payment Receipt;
   - Discharge Summary/ Card;
   - All Investigation Reports;
   - Bills and receipts for investigations done outside the hospital;
   - Prescription, Pre hospitalization bills;
   - Bills of medicines and surgical appliances purchased by employee.

2. The HR Department shall forward the verified papers to ICICI Lombard I – Health Care for processing the claim.

(C) This policy is also applicable for medical expenses incurred one month prior and two months post hospitalization; Employees may submit a supplementary claim along with relevant documents in this regard.

(D) Reimbursement of room rent per day of the hospital shall be capped at 1% of the total sum insured; Excess of the same will result in proportionate deduction from the entire claim amount.

GROUP PERSONAL ACCIDENT INSURANCE POLICY

Objective

To compensate the insured employees in case of absence from work due to accidental death, permanent total disablement, permanent partial disablement and temporary total disablement.

Scope

All employees of the Phoenix Group who are not covered under Employees’ State Insurance Scheme of India.
**Policy Details**

**General Guidelines**

1. This policy is being provided by an Insurance Company (currently ICICI Lombard) and administered by the Corporate HR Department, and the amount of premium is borne by the company.
2. The amount of coverage for all eligible employees shall be 30 months’ Basic Salary, subject to a maximum of Rs 50 Lakhs.
3. All other conditions applicable for benefits shall be as per the regulations of the Insurance Company.

**Process Details**

- In case of accident, the claimant is required to intimate the Corporate HR Department within 24 hours, who shall further inform the Insurance Company.

- All claim documents shall be submitted by the claimant to the Corporate HR Department, who shall further submit the same to the Insurance Company for settlement of claims.

- Documents required in case of Accidental Death:
  - Claim Form, duly filled and signed by nominee;
  - Post Mortem Report (certified copies);
  - F.I.R. or Accident Death Report or Inquest Panchnama (in original or certified copies);
  - Spot Panchnama (certified copies);
  - Death Certificate (in original or certified copy);
  - Any other document as may be required by the Insurance Company.
Documents required in case of Accident resulting into Permanent Total Disablement / Permanent Partial Disablement / Temporary Total Disablement:

- Claim Form, duly filled and signed by the claimant;
- Disability Certificate, stating percentage of disablement, by Authorized Medical Officer/ Civil Surgeon of Civil Hospital/ Govt. Hospital of the District/ Units concerned;
- F.I.R. and Panchnama wherever applicable (original or certified copies);
- Medical Report;
- Investigation Reports like laboratory test, X-rays and reports essential for confirmation of the type and percentage of disability;
- Original medical bills;
- Photo of injured showing the disability;
- Any other document as may be required by the Insurance Company.

In case the claim documents are incomplete, the Insurance Company shall send to the claimant a query letter for submission of required claim documents; The claimant shall be required to submit the same within a given time period from the date of receipt of the query letter.

Post processing the claim, if the claim is to be paid, the claimant shall receive the claim amount from the Insurance Company by way of cheque or electronic fund transfer or demand draft.

Post processing the claim, if the claim is to be repudiated, the claimant shall receive a repudiation letter accordingly from the Insurance Company.