Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai- 400013
Email: care@libertyinsurance.in
IRDA registration number: 150 • CIN: U66000MH2010PLC209656

<table>
<tr><th>Sl. No.</th><th>Title</th><th colspan="6">CUSTOMER INFORMATION SHEET
DESCRIPTION IS ILLUSTRATIVE AND NOT EXHAUSTIVE
*This document provides key information about your policy. You are also advised to go through your policy document. In case of any conflict, the terms and conditions mentioned in the Policy document shall prevail.</th><th>Policy Clause Number</th></tr>
<tr><td>1</td><td>Name of the Insurance Product/Policy</td><td colspan="6">Secure Health Connect</td><td>NA</td></tr>
<tr><td>2</td><td>Policy Number</td><td colspan="6"></td><td>NA</td></tr>
<tr><td>3</td><td>Type of Insurance Product/Policy</td><td colspan="6">Indemnity</td><td>NA</td></tr>
<tr><td>4</td><td>Sum Insured</td><td colspan="6">Individual/Family Floater policy –
Insured 1
Insured 2
Insured 3
Insured 4</td><td>NA</td></tr>
<tr><td rowspan="3">5</td><td rowspan="3">Policy Coverage (What the policy covers?)</td><td colspan="6">Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your Plan as specified in the Policy Schedule.</td><td rowspan="3">Part D.1-11 of the Policy.</td></tr>
<tr><td colspan="2">Policy Plans</td><td>Secure Basic</td><td>Secure Elite</td><td>Secure Supreme</td><td>Secure Complete</td></tr>
<tr><td>Sr. No.</td><td>Coverage’s Description</td><td>Sum Insured 2, 3, 4, 5 lakhs</td><td>Sum Insured 2, 3, 4, 5, 7.5, 10 lakhs</td><td>Sum Insured 3, 4, 5, 7.5, 10 lakhs</td><td>Sum Insured 2, 3, 4, 5, 7.5, 10, 15 lakhs</td></tr>
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		1	In-patient Hospitalization	Covers Hospitalization expenses for a period more than 24 hours as an In-patient. Room rent/ICU and associated charges available as per the Plan opted.	**Room Rent sub limit:** 1% of Sum Insured or maximum up to INR 3000/ day whichever is lower **ICU sub limit:** 2% of Sum Insured or maximum up to INR 6000 /day whichever is lower	**Room Rent sub limit:** 1% of Sum Insured or maximum up to INR 5000/ day whichever is lower **ICU sub limit:** 2% of Sum Insured or maximum up to INR 6000 /day whichever is lower	**Room Rent sub limit:** 1% of Sum Insured or maximum up to INR 5000/day whichever is lower **ICU sub limit:** 2% of Sum Insured or maximum up to INR 7500/day whichever is lower	**Room Rent sub limit:** 1% of Sum Insured or maximum up to INR 2500/ day whichever is lower **ICU sub limit:** 2% of Sum Insured or maximum up to INR 5000/ day whichever is lower	
		2		Medical expenses	30 DAYS	30 DAYS	45 DAYS	30 DAYS	

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			Pre Hospitalization	incurred prior to the covered Hospitalization	Medical Expenses up to 1% of Sum Insured accrued up to maximum 30 days.	Medical Expenses up to 1% of Sum Insured accrued up to maximum 30 days.	Medical Expenses up to 1.5% of Sum Insured accrued up to maximum 45 days.	No Sub limits applicable	
		3	PostHospitalisation	Medical expenses incurred after the covered Hospitalization	45 DAYS	45 DAYS	60 DAYS	45 DAYS	
					Medical Expenses up to 1% of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1% of Sum Insured accrued up to maximum 45 days.	Medical Expenses up to 1.5% of Sum Insured accrued up to maximum 60 days.	No Sub limits applicable	

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		4	Day care Procedures	405 day care procedures as listed in the Policy document, undertaken in a hospital/ day care Centre in less than 24 hours due to Technological advancement.	√	√	√	√	

		5	AYUSH Treatment# (# Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024)	"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	
		6	Emergency Local Road Ambulance Charges	Emergency Ambulance charges for transferring to the nearest Hospital	1% of SI , subject to max INR 1,000 per Insured per year	1% of SI , subject to max INR 2,000 per Insured per year	1% of SI , subject to max INR 3,000 per Insured per year	X	

		7	Daily Cash Allowance	Daily cash allowance of up to 10th day of continuous hospitalization. A deductible of first 48 hours of hospitalization is applicable	X	X	X	INR 500 / per day	
		8	Cumulative Bonus	Auto increase in Sum Insured for every claim free year	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 10% Max up to 50%	Per Year: 25% Max up to 100%	
		9	Sub limits on Medical Expenses	Disease wise sublimit as per Annexure attached	√	√	√	√	

		10	Co-Pay	Nonnetwork Hospital: 10 % Co-pay Insured above 60 years: 10% Co-Pay	√	√	Co-Pay Not Applicable	√	
		11	Health Check up	Per Insured Person 18 yrs. and above limited to max 2 adult Insured/s, Health Check up at every 2 continuous claim free renewal.	√	√	√	√	
		12	Stay Fit Perks	Additional perks on every block of two claim free Policy renewals with Us	SI up to INR 5 Lakh: Lump sum amount of INR 3000	SI up to INR 5 Lakh: Lump sum amount of INR 4000	SI up to INR 5 Lakh: Lump sum amount of INR 5000	SI up to INR 5 Lakh: Lump sum amount of INR 4000	

				as per the SI and Plan opted. This will be accumulated in your Policy automatically and may be utilized after the 2nd claim free Policy renewal against any deduction as applicable under the Policy		SI above INR 5 Lakh: Lump sum amount of INR 5000	SI above INR 5 Lakh: Lump sum amount of INR 7000	SI above INR 5 Lakh: Lump sum amount of INR 5000	
		Optional Cover(s)							
		1	Reload of Sum Insured	Sum Insured can be reloaded equivalent to the original Sum Insured opted.	√	√	√	√	Part D Optional Covers : 1-3 the Policy

		2	Enhanced Cumulative Bonus	Total Cumulative Bonus (Cumulative Bonus + Optional Cover Cumulative Bonus) per year shall be enhanced by opting this option and as per the Plan opted.	Per Year: 20% Max upto 100%	Per Year: 25% Max upto 100%	Per Year: 30% Max upto 150%	X	
		3	Waiver of Medical Expenses Sub limits	Sub limits as specified in the Annexure are waived off by opting this Optional Cover	√	√	√	√	

6	Exclusions (What the policy does not cover)	**Standard Exclusions** **1. Pre- Existing Diseases** a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded as per the Plan mentioned in the Policy schedule i.e.until the expiry of 36 months months of continuous coverage after the date of inception of the first policy with Us. b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase. c. 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. d. 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** 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. **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. c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently. **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	Part E.i. of the policy

		to the current diagnosis and treatment are excluded. **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. **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 co-morbidities 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 **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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim. **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 **18. Maternity** i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.	

		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 IITLB-III) 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 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 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	Part E.ii. of the policy

		before/pursuant to inpatient Allopathy treatment. The above exclusions are in additions to the General exclusions listed under the Policy. #Added pursuant to "Guidelines on providing AYUSH Coverage in Health insurance policies" dated 31 January, 2024 issued by the IRDAI effective 1st April 2024 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, 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 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 E.i.1,2 &3 of the policy
8	**I. Sub-limit** (It is pre-defined limit, and the insurance	The Medical Expenses incurred during any Hospitalization due to the below listed treatments shall be limited to actual expenses or up to the Sub limits (whichever is less) as stated below. All values are in INR. Excluding taxes.	Benefit Schedule

	company will not pay any amount in excess of this limit)	**Procedure/Treatment**	**Policy Plans**				& Annexure of the Policy
			Secure Basic	**Secure Elite**	**Secure Supreme**	**Secure Complete**	
		Cataract per eye	20,000	30,000	40,000	40,000	
		Hysterectomy	35,000	45,000	55,000	55,000	
		Removal of gall bladder	35,000	45,000	55,000	55,000	
		Surgery for piles	20,000	30,000	40,000	40,000	
		Surgery for fissure, fistula and sinus	20,000	30,000	40,000	40,000	
		Surgery for nasal septum correction	20,000	30,000	40,000	40,000	
		Angiography invasive	15,000	20,000	30,000	30,000	
		PTCA	80,000	120,000	150,000	150,000	
		Appendectomy	30,000	40,000	50,000	50,000	
		D & C	10,000	15,000	20,000	20,000	
		Hernia	35,000	45,000	55,000	55,000	
		Deviated Nasal Septum	35,000	45,000	55,000	55,000	
		Surgery for renal stone	35,000	45,000	55,000	55,000	
		Prostate Surgery TURP	75,000	100,000	120,000	120,000	
		CABG	100,000	150,000	200,000	200,000	
		Total Knee replacement per knee	80,000	120,000	150,000	150,000	
		Total Hip replacement	80,000	120,000	150,000	150,000	
		In case of a claim, this policy requires you to share the following costs: Expenses exceeding the following: **Sub-limits** * Room / ICU charges: as per the Policy Plan chosen. * For the following specified diseases: sub-limits are applicable as per the Policy Plan chosen however this is not applicable if selected Optional cover “Waiver of Medical Expenses Sub limits”.					

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	II. Co-Payment (It is a specified amount/percentage of the admissible claim amount to be paid by policyholder/insured).	**Co-Payment** For all admissible claims in non-network hospitals, Insured shall bear 10% of the admissible claim and in respect of Insured above 60 years, 10% co-pay will be applied on all admissible claims irrespective of network/non-network hospital.	Part D.9.of the policy
	III. Deductible (It is a specified amount – up to which an insurance company will not pay any claim, and which will be deducted from total claim amount (if claim amount is more than the specified amount)	**Deductible** A deductible of first 48 hours of hospitalization is applicable.	
	IV. Any other limit (as applicable)		

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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. 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. 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 iv. Hospitals which are blacklisted or from where no claims will be accepted by insurer – https://www.libertyinsurance.in/Docx/ExcludedHospitalLists.pdf **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	Part G.7. of the policy	

		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. All claim related documents needs to be submitted within 7 days from the date of completion of treatment as mentioned in the policy schedule -. 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 30 working days of receipt of the last required documents. **b. 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 number 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 Hospitalization medical expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorization letter to the health care service provider. ii. For the purpose of considering Pre-Authorization 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. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorization to the Hospital concerned for cashless facility whereby hospitalization medical expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorization. iii. 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 medical expenses and claim reimbursement immediately after discharge from the Hospital. iv. 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. v. In case where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer(if covered under any other Health Insurance Policy). **c. Reimbursement:** 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/ Nursing Home 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 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 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. **d. Claim Service Assurance:** Cashless Service Assurance: If the Insured / Insured person notifies a cashless facility request by sending the Pre- Authorization form duly filled in and signed through email, fax to the Company / TPA or its representative then within 6 Hours of the actual receipt of such a request the Company / TPA will		

		respond with: a. Approval, or b. Rejection If such request has been notified during office hours (9am to 6pm) on Monday to Friday and the Company/TPA fails to either approve or reject or seek further information after the expiry of 6 Hours from the actual receipt of such a request then the Company shall be liable to pay the Insured for the delay in the following manner: i. For Delay beyond 6 hours Rs 1500/- ii. The Maximum amount the Company shall be liable to pay for any delay, in respect of a single hospitalization, shall at no time exceed Rs 1500/- The Company will not be liable to make any payments under the above clause in case of any natural event or manmade disturbance which impedes the Company's ability to make a decision or communicate such decision to the Insured/Insured Person. Any amount paid under the Clause will not affect the Sum Insured as specified in the Schedule. That the Company's liability to make payments under the Clause shall at all times be restricted to the amounts specified including the maximum amount specified therein and the Insured shall not be entitled to any sum whatsoever, in excess of those amounts. That any Payment made under this clause by the Company will not account to any admission of liability for a claim notified by the Insured. Service Assurance is applicable only to the first response on a single claim and no subsequent correspondence. **CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM** **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. Road Traffic Accident **In addition to the In-patient Treatment documents:** q Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate. In Non Medico legal cases q Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained) In Accidental Death cases q Copy of Post Mortem Report (if conducted) & Death Certificate **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 (where nomination is not available) **Pre and Post-hospitalisation medical 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. **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) 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 Ltd. 15th Floor, Unit-1501&1502, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai- 400013 **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 F.i.16 of the Policy	
11	Grievances/Complaints	• For Grievance Redressal, please refer: https://www.libertyinsurance.in/customer-support/grievance-redressal.html • Bima Bharosa (Grievance Redressal Portal), IRDAI :https://bimabharosa.irdai.gov.in/	Annexure-B	

		• Insurance Ombudsman - For the latest details of Ombudsman offices, please visit the Insurance Ombudsman website at the following link: https://www.cioins.co.in/Ombudsman Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.		
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 F.i.15 of the policy Part F.i.10. of the policy	

		Migration: 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. **Portability:** 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. lf 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** Sum insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured. **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	Part F.i.8. of the policy Part F.i.9. of the policy Part F.i.12. of the policy	

		policies shall be counted for the purpose of calculating the Moratorium period.		
13	Your Obligations	* Please disclose all pre-existing disease/s or condition/s before buying a policy. * Disclosure of Material Information during the policy period that relates to questions in the Proposal Form and which is important to the Company in order to accept the risk of insurance. Such information need to be provided to us in the form named as 'Alteration in Risk form' available on our Company website www.libertyinsurance.in before the Renewal, extension, variation, endorsement or reinstatement of the contract	Part F.i.1 & 2	

Liberty General Insurance Ltd.
15th Floor, Unit-1501&1502, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai- 400013
Email: care@libertyinsurance.in
IRDA registration number: 150 • CIN: U66000MH2010PLC209656

For Policy related documents visit our website-

https://www.libertyinsurance.in/customer-support/download-forms.html\

Declaration by the Policy Holder:

I have read the above Customer Information Sheet along with Policy documents and confirm having noted the details:

Place: Date: Signature of the Policyholder: