Frequently Asked Questions

- **What is the meaning of insurance?**
  Insurance is a protection against financial loss arising on the happening of an unexpected event. Insurance is a mechanism of collection of small amounts of premium from many individuals or firms out of which losses suffered by a few are compensated.

- **Who is an insured?**
  The party to an insurance arrangement whom the insurer agrees to indemnify for losses, provide benefits for, or render services to. This term is preferred to such terms as policyholder, policy owner, and assured.

- **Who is an insurer?**
  The party to an insurance arrangement who undertakes to indemnify for losses, in general, insurance company.

- **What do you mean by annual sum insured?**
  The annual (basic) sum insured is the maximum amount that an insurance company will pay you, according to the insurance contract, in the event of a claim.

- **What do you mean by Premium?**
  The **amount paid to avail the covers** in the policy is called premium.

- **What do you mean by period of the policy?**
  Policy Period is the **period for which the policy is valid**.

- **What do you mean by Date of Inception?**
  Date of inception is the **date** from which the **policy becomes valid**.

- **What are the tax benefits that can be availed on this plan?**
  In Group Health policies, you will be eligible for tax benefit as per the existing income tax benefits under 80D, only if premium is paid/contributed by you.

- **What is the difference between individual and Floater Sum Insured (SI)?**
  In case of Individual SI, separate Sum Insured is allotted for every individual of a family. Whereas, Floater covers all in family and provides one sum insured to all. (should be referred as definition only)

- **What do you mean by sublimit?**
  Sublimit defines the capping of insurance amount for specific surgeries and medical procedures.

- **What do you mean by waiting period?**
  The duration only after which a claim can be made is called the waiting period. It will be applicable in case the company has opted for it.
- **What do you mean by pre-existing disease?**
  Any condition, ailment or injury or related condition(s), for which you had signs or symptoms and/or were diagnosed and/or received medical advice/treatment within 48 months prior to the first policy inception with the insurance company is called a pre-existing disease. Applicability will be as per policy Terms and Conditions.

- **What do you mean by Reimbursement?**
  The amount **paid back by the insurer for the expenses incurred by the insured** is called reimbursement.

- **What do you mean by Co-payment?**
  Co-Payment is a cost-sharing mechanism under a health insurance Policy that provides the policyholder/ insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured. Applicability will be as per policy Terms and Conditions.

- **What are the covers offered under basic hospitalization?**
  It refers to payment of the in-patient hospitalization expenses such as boarding and nursing expenses, intensive care unit charges, surgeon's/doctor's fee, anesthesia, blood, oxygen, operation theatre charges etc. incurred by you during hospitalization for a minimum period of 24 consecutive hours.
- **What are the covers offered under Day care Surgeries/Treatments?**
  It refers to payment of the **Medical Expenses incurred** by the insured while undergoing **Specified Day Care Procedures/Treatment** (as mentioned in the Day Care Surgeries list on our website), which require **less than 24 hours Hospitalization.**

- **What are the covers offered under Pre and Post Hospitalization Expenses?**
  Pre-hospitalization refers to payment of the **Medical Expenses incurred** by the insured before admission to the hospital. Post-hospitalization refers to medical expenses i**mmediately after Hospitalization**. The number of days will be specified in your policy

- **What do I do in case of a claim?**
  In case of a planned hospitalization or emergency services, use your Health ID Card at any of our network hospitals on website gmcclaims@tataaig.com and avail cashless service. Call helpline number 1800 26 77123 which is printed on your health cashless card for assistance.

- **What is claim intimation?**
  All the claims have to be intimated 48 hours prior to hospitalization in case of planned admission and within 24 hours post admission in case of emergency

- **What is the procedure for reimbursement settlement?**
  Submit duly filled in claim form along with relevant documents suggested as per the checklist. Decision on the claim will be conveyed upon reviewing the submitted documents. In case of deficiency, claim will be queried for additional information/documents. Communications will be sent on registered mail id/ phone number through-out journey of the claim.

- **What are the steps to avail reimbursement process?**
  In case, insured admits in non-network hospital and paid hospitalization expenses directly, then TATA AIG will later reimburse you for the medical bills as per policy Terms and Conditions.

1. Make sure you collect all the paid bills with their break up details dully signed and stamped by hospital authority. Also collect a copy of treatment records like indoor case papers/treatment charts/vitals charts etc.

2. Submit/courier specified documents to the mentioned address for reimbursement.

3. Within 30 days from the discharge date above mentioned documents to be submitted at respective.

4. In case submitted documents full fill the need of processing the claim, the settlement of claimed amount will be credited to your account with in 15 days on the receipt of last document received.

- **List of documents needed to avail Reimbursement:**

  • Duly filled in and signed Claim form
  • Claim Forms available on website - https://www.tataaig.com/downloads
  • Insurance Card or Policy Copy
  • Medical Certificate signed by the doctor
  • Original discharge summary & Original consolidated final bill
  • Break ups required for the submitted final bill
  • Cash paid receipts of hospital/pharmacy/lab
  • Bank details of proposer with printed cancelled cheque copy/ passbook copy
  • Supportive investigation reports.
  • In case of implants used, invoices are required.
  • In case of Accidental injuries, MLC/ FIR required.
  • In case of death of main member, details of nominee (as per policy schedule), along with address & ID proof of nominee

- In case claim value is above Rs. 1 lakh, CKYC form with mandatory columns filled, with photograph of main member and cross signed on it

- **What is the process for claim?**
  - The claim process involves 3 steps
    - Claim Intimation
    - Claim Processing
    - Claim Payment/Closure

    Claim can be intimated through various modes:
  - Call center
  - E-mail
  - SPA

- **What are the steps for cashless process?**

In case of hospitalization in our network hospitals, you don't need to pay anything to hospital for the covered expenses; Tata AIG will directly pay to the hospital on your behalf.

a. Approach insurance help desk in our network hospital with required documents.

b. Insurance desk will send us the duly filled pre-authorization form along with supportive medical records.

c. On receipt of preauthorization request from hospital, we will check payable/admissible amount and approve cashless facility as per policy terms and conditions.

d. After discharge you can avail pre and post hospitalization medical expenses through reimbursement process as mentioned.

List of documents needed to avail cashless facility:

- Insurance Card / Policy Copy
- Copy of Company photo ID.
- Customer Address Proof.
- Duly Filled CKYC Form if Claimed amount is above Rs 1L.
- Admission notes from treating doctor.
- Previous OPD consultation papers with reports if any.

- Previous discharge summary or any other medical records available with you.
- Any previously approved / settlement letter from Tata AIG for reference. (Optional)

- **Where should I submit my claim documents?**
  After claim intimation customer has to submit hard copy (original documents) related to hospitalization to Hyderabad branch, by hand or by courier. Customer has to mentioned their claim intimation ID on top of the envelop/claim documents file.

  Hyderabad branch address:
  Corporate Health Claims Processing Hub,
  TATA AIG General Insurance Company Limited
  5th and 6th Floor, Imperial Towers, Ameerpet,
  Next to Ameerpet Metro Station, Hyderabad, Telangana - 500016

  On receiving the claim documents at Hyderabad branch, customer will receive the claim registration ID on his/her mobile no. and e-mail ID.

  Claim intimation can be done through soft copies via self-service portal https://www.tataaig.com/servicing

- **For any queries, how can I contact you?**
  In case of any assistance, kindly call us on
  - Toll free number 1800 26 77123
  - E- mail us at gmcclaims@tataaig.com

- **Will I get money if I visit a clinic or doctor for consultation or OPD treatment?**
  OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient. OPD will be covered if it has been opted and the limit is mentioned in the policy copy.

- **Does my policy cover OPD expenses as well?**
  OPD will be covered if it is mentioned in the policy copy up to the limit. You may refer policy copy or co-ordinate with concerned person of your company to obtain more clarity on this.

- **Which all OPD treatments are covered?**

  OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner.

- **What is the meaning of Network hospital?**

  Network Provider or Hospital means hospitals or health care providers empaneled by us to provide medical services to an insured by a cashless facility.

- **What is the meaning of non-network hospital?**

  Non-network Provider or Hospital means hospitals or health care providers which are not empaneled by us but provide medical services to the patients.

- **Will I get money if I go to non-network hospital?**

  In case, insured admits in a non-network hospital, he/she has to bear the hospitalization expenses directly, later can reimburse the expenses by following the claim process with us.

- **Will the insurance company reimburse money for the whole hospital bill?**

  For admissible cases, reimbursement will be processed as per the terms and conditions of the policy. Insured needs to pay for the non-payable expenses.

- **Will everything be covered by this insurance?**

  If claim is admissible under the policy, it shall be processed based on the expenses incurred on treatment or pay for the listed benefits up to sum insured. The said treatment must be on the advice of a qualified Medical Practitioner. Insured needs to pay for the non-payable expenses.

- **What is the meaning of TPA? How TPA is different from Insurance company?**

  TPA stands for Third Party Administrator. It acts as a mediator between the insurance provider & the insured individuals. Its primary role is to address all cashless and reimbursement claims linked to hospitalization and medical expenses.

- **Is there a waiting period for making any claims?**
  - Initial waiting period of 30 days is applicable from the policy inception date; however, accidents are covered from policy start date. Applicability will be as per policy Terms and Conditions..
  - Specified disease or procedure waiting period will be applicable as per policy opted.

- Waiting period will be applicable on pre-existing diseases based on policy terms and conditions.

- **Does it cover endemic/pandemic?**
  It will be considered as per policy terms and conditions and IRDA guidelines.

- **Does it cover COVID 19?**
  Yes, and it will be covered as per IRDA guidelines.

- **How many days I have to wait to get reimbursement after submission of bills?**
  Claim will be processed within 14 days after receiving all the mandatory documents/ the last document received date.

- **How do I check whether any ailment/procedure is covered under the policy?**
  Benefit covered can be checked from the policy copy or day care procedure list available on the website
  https://www.tataaig.com/s3/Others_List_of_Day_Care_Procedures_31a44748f1.pdf

- **How do I claim from 2 different policies if SI of one policy is exhausted?**
  In case You are claiming for the same event under an indemnity-based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

- **Do I need to pay any amount in case of cashless claims?**
  If the claim is admissible, we will directly pay to the hospital. If any Non-payables are to be borne by the customer.

- **Shall I get money if Allopathy treatment is given by a Homeopathy or Ayurvedic doctor?**
  Treatment rendered by a Medical Practitioner which is outside his discipline is not payable.