APPENDIX - 1

ORIGIN AND GROWTH OF INSURANCE

The practice of pooling resources to ensure protection against risk of ill health grew mainly out of labour developments. In medieval, Europe craftsman formed societies (guilds) which in turn created funds to help members in times of distress due to sickness\(^1\). Each member contributed on a regular basis. Industrialization stimulated broader and more varied arrangements for dealing with the hazards of ill health. From the late 18\(^{th}\) and early 19\(^{th}\) century group of workers and small farmers in the same industry or location formed sickness funds as mutual benefits. Societies to serve the needy or not to gain profits.

Germany was the first to exploit the potential health insurance in 1883. The Government enacted legislation to create sickness fund and this would be financed through compulsory contribution of workers and employers. This marked the beginning of health insurance mechanism, which gradually spread throughout Europe. 90% of the population is covered by the statutory health insurance system which is generally considered expensive but provides comprehensive and high quality services. Due to the process of rising costs, Germans have resorted to new alternative forms of controlled and organized health care based on the philosophy of managed care.

Following the German example Austria introduced health insurance in 1887, Norway in 1902, U.K in 1910 and France enacted health insurance in 1921, with implementation only in 1930. By the early 1930's compulsory health insurance had been developed in most of the industrialized countries of Europe, under the name of sickness and maternity insurance.

A different form of payment was later introduced, first in Norway, and then in France. The patient paid the doctor directly after the consultation and treatment, according to the stipulated fees for the actual services provided, and then the major part of this expenditure (80%) was refunded by the social insurance administration. In Southern Europe (Greek, Portugal, Spain) a national pattern developed with compulsory health insurance managed by large and broad based public institutions enjoying administrative and financial autonomy.

Health insurance was administered by multitude of funds, affiliated with occupational sectors or other specific groups of individuals in several European countries (Belgium, France, Germany, the Netherlands).

In 1919 the International Labour Organization became a major forum where health insurance policies were debated. The practice of medicine changed significantly, increasing in number and complexity with broader scope. The disappearance of large charitable hospitals with religious volunteers or extremely low paid nursing staff made medical care more effective and far more expensive.
The emergence of the concept of 'social security' from the late 1930's had a major impact on health insurance. The security which the society should provide for the people, through a series of public measures to safeguard them against the substantial reduction of earnings resulting from sickness, maternity, employment, injury, employment invalidity, old age and death

Medicare was introduced in 1965 under Title XVIII of the Social Security Act to help older persons in America to obtain and pay for medical care. In the early 1960s before Medicare, only about half of older Americans had any health insurance, compared to 75 percent of those under 65. Some seeking private coverage were denied on the basis of age or pre-existing conditions, others could not afford it. Medicare is divided into two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) which represent two of the four Social Security Trust Funds (the others address retirement / survivors and disability income). In 1972, the program was extended to certain people under age 65: those with kidney failure and those receiving Social Security Disability Insurance (DI) benefits for at least two years.

Two trust funds are used to finance the Medicare program, the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. Current employees and their employers each pay 1.45 percent of a worker's salary (self employed workers pay 2.90 percent) to HI. The trust fund also receives interest earned on trust fund balances and revenue from some taxes on Social Security benefits. The HI trust fund, in contrast to the
Social Security retirement trust fund is not accumulating a large balance for future years. It is operating largely on a “pay-as-you-go” basis. Because of the rapid health cost spiral, lifetime Medicare benefits are much greater than the average worker pays in, although the ratio has declined due to recent increases in the payroll tax. SMI is financed by premium contributions of enrollees (covering about 25 percent of costs) and from general federal revenue (covering the remaining 75 percent). The SMI Trust Fund is not designed to accumulate funds for future benefit payments.

Medicaid is the largest insurer of long term care for all Americans, including the middle class. Medicaid covers 68 percent of nursing home residents and over 50 percent of nursing home costs. Medicaid covers skilled nursing facility care, intermediate care facilities for the mentally retarded and developmentally disabled, and home and community based services. Although most long term care spending is for institutional care, Medicaid has made great strides in shifting the delivery of services to home and community settings.

The Canada Health Act received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which came into force on April 1, 1984, repealed the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. The purpose of the Canada Health Act is to establish criteria and conditions in respect of

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3 Health insurance - Canada - Assurance - Sante: Medicare healthsc.gc.ca p.1
insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.”

The insured health services defined by the Canada Health Act include all medically necessary hospital services and medically required physician services, as well as medically or dentally required surgical-dental services requiring a hospital for their proper performance. Extended health care services (EHCS) payments are made in respect of nursing home intermediate care, adult residential care, home health care, and ambulatory health care. The services are part of a broad range of health and social services offered by a variety of community and institutional programs and facilities to residents of a province. The majority of residents using these services are aged 65 and over.

Switzerland was the first European country to adopt organized health care of the managed care style on a broad scale. Cost savings between 10 to 70% have been achieved for patients. Managed care covers and traditional care covers are in operation. But managed care organization have gained considerable cost advantage.

The evolution of compulsory health insurance in developing countries is less known. Developing countries had to adopt the approach according to their aspirations and the availability of funds. The developments in health insurance came about gradually in developing countries. The economic and social background against which the developing countries have to contemplate further progress in the health sector is constantly changing and
compulsory health insurance is one of the options that governments have been paying attention to. The serious shortages in the allocation of resources from state or from local health budgets, drives the need to mobilize additional resources and the promising option was compulsory health insurance in the form of a social security programme.
APPENDIX - II

PROSPECTUS

MEDICLAIM INSURANCE POLICY

Salient Features of the Policy

1.1 The policy covers reimbursement of Hospitalisation / Domiciliary Hospitalisation expenses for illness diseases or injury sustained.

1.2 In the event of any claim becoming admissible under this scheme, the company will pay to the Insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured person, but not exceeding the Sum Insured in aggregate in any one period of Insurance stated in the schedule hereto.

a. Room, Boarding Expenses as provided by the Hospital / Nursing Home.

b. Nursing Expenses.

c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists fees.

d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses.
(N.B. Company’s Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person mentioned in the Schedule).

1.3 This insurance scheme also provides for

a. Family discount in premium (refer item 6)

b. Cumulative Bonus (refer item 9)

c. Cost of Health Check-up (refer item 10)

(N.B. Renewal of Insurance without break is essential)

2. Definitions:

2.1 Hospital / Nursing Home means any institution in India established for indoor care and treatment of sickness and injuries and which Either

a. has been registered either as a Hospital of Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner.

b. Should comply with minimum criteria as under:

i. it should have at least 15 in patient beds.*

ii. Fully equipped operation theatre of its own wherever surgical operations are carried out.

iii. Fully qualified Nursing Staff under its employment round the clock.
iv. Fully qualified Doctor(s) should be in-charge round the clock.

(N.B.* In Class `C' town condition of number of beds be reduced to 10).

2.1.1 The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug – addicts or place for alcoholics, a hotel or a similar place.

2.2 "Surgical Operation" means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief or suffering and prolongation of life.

2.3 Expenses on Hospitalisation for minimum period of 24 hours are admissible. However, this time limit is not applied to specific treatments i.e. Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Dental Surgery, Lithotripsy (Kidney stone removal), Tonsillectomy, D & C taken in the Hospital / Nursing Home and the Insured is discharged on the same day, the treatment will be considered to be taken under Hospitalisation Benefit.

2.4 Demiciliary Hospitalisation Benefit means

Medical treatment for a period exceeding three days for such illness / disease / injury which in the normal course would require care and treatment at a Hospital/Nursing Home but actually taken whilst confined at home in India under any of the following circumstances namely.
i. The condition of the patient is such that he/she cannot be removed to the Hospital / Nursing Home or

ii. The patient cannot be removed to hospital / Nursing Home for lack of accommodation therein.

Subject however that domiciliary hospitalisation benefits shall not cover

i. expenses incurred for pre and post hospital treatment and

ii. expenses incurred for treatment of any of the following diseases.

1. Asthma
2. Bronchitis
3. Chronic Nephritis and Nephrotic Syndrome
4. Diarrhoea and all type of Dysenteries including Gastro-enteritis
5. Diabetes Mellitus and Insipidus
6. Epilepsy
7. Hypertension
8. Influenza Cough and Cold
9. All Psychiatric or Psychosomatic Disorders
10. Pyrexia of Unknown Origin for less than 10 days
11. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
When treatment such as Dialysis, Chemotherapy, Radiotherapy etc, is taken in the Hospital Nursing Home and the Insured is discharged on the same day, the treatment will considered to be taken under Hospitalisation Benefit section.

Liability of the Company under this clause is restricted as stated in the schedule attached hereto.

3.0 Any one illness

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment may have been taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

3.1 Pre-Hospitalisation

Relevant medical expenses incurred during period upto 30 days prior to hospitalisation on disease / illness / injury sustained will be considered as part of claim mentioned under item 1.2 above.

3.2 Post-Hospitalisation

Relevant medical expenses incurred during period upto 60 days after Hospitalisation on disease / illness / injury sustained will be considered as part of claim as mentioned under item 1.2 above.

3.3 Medical Practitioner means a person who holds a degree / diploma of a recognised institution and is registered by Medical council of respective State of India. The term Medical Practitioner would include Physician, Specialist and Surgeon.
3.4 Qualified Nurse means a person who holds a certificate of a recognised Nursing Council and who is employed on recommendation of the attending Medical Practitioner.

4. Exclusions

4.0 The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 All diseases / injuries which are pre-existing when the cover incepts for the first time.

4.2 Any Disease other than those stated in clause 4.3, contracted by the Insured Person during the first 30 days from the commencement date of the policy.

This exclusion shall not however, apply if in the opinion of Panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the Disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company. The conditions 4.2 shall not however apply in case of the insured person having been covered under this scheme or group insurance scheme with any of the Indian Insurance Companies for a continuous period of preceding 12 months without any break.

4.3 During the first year of the operation of insurance cover, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal diseases, Fistula in Anus, Piles, Sinusitis and related disorders are not payable.
Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (Whether war be declared or not).

Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

Cost of spectacles and contact lenses, hearing aids.

Dental treatment of surgery of any kind unless requiring hospitalisation.

Convalescence, general debility, “Run-down” condition or rest cure, congenital external diseases or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs / alcohol.

All expenses arising out of any condition directly or indirectly caused due to or associated with Human T-Cell Lymphotropic Virus type III (HTLV-III) or Lymphadinoopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

Charges incurred at Hospital or Nursing Home primarily for diagnostic, x-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
4.11 Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Physician.

4.11.1 Injury / Disease directly or indirectly caused by or contributed to by nuclear weapons / materials.

4.12 Treatment arising from or traceable to pregnancy, childbirth including Caesarean section.

4.12.1 Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.


5. **Age Limit**

   This insurance is available to persons between the ages of 5 years and 80 years. Children between 3 months and 5 years of age can be covered provided one or both parents are covered concurrently.

6. **Family Discount**

   6.1 A discount of 10% in the total premium will be allowed for family comprising of the insured and any one or more of the following:

   i. Spouse

   ii. Dependant Children (i.e. legitimate or legally adopted children)

   iii. Dependant Parents.

7. **Notice of Claim**

   7.1 Preliminary notice of claim with particulars relating to policy numbers, name of 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 the insurance
company within seven days from the date of hospitalisation / injury / death.

7.2 Final claim along with hospital receipts bills/cash memos, claim form and documents as listed in the claim form should be submitted to the company within 30 days of discharge from the Hospital.

Note: Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

8. **Payment of Claim**

All claims under this policy shall be payable in Indian currency. All medical treatments for the purpose of this insurance will have to be taken in India only.

9. **Cumulative Bonus**

Sum insured under the policy shall be progressively increased by 5% in respect of each claim free year of insurance. Subject to maximum accumulation of 10 claim free years of insurance.

9.1 In case of a claim under the policy in respect of insured person who has earned the cumulative bonus the increased percentage will be reduced by 10% of sum insured at the next renewal. However, basic sum insured will be maintained and will not be reduced.

10. **Cost of Health Checkup**

In addition to cumulative bonus, the insured shall be entitled for reimbursement of cost of medical check-up once at the end of block of every four underwriting years provided there are no claims reported
during the block. The cost of reimbursable shall not exceed the amount equal to 1% of the average Sum Insured during the block of four claims free underwriting years.

N.B. For Cumulative Bonus and Health Check-up provisions as aforesaid:

1. Both Health Check-up and Cumulative bonus provisions are applicable where period of insurance as stated in the schedule attached hereto has commenced not later than a week after the expiry of the last Mediclaim Insurance policy, although renewal is allowed subject to medical check-up.

2. Cumulative Bonus as accrued to the credit of the same policy holder will be added to sum insured under this policy.

3. Health Check-up benefit will be accrued in case of the policy holder where policy year has commenced.

11. This insurance policy is issued for a period of one year and subject to review. Continuation of insurance cover will be available if the renewal premium is paid in time. On continuation of insurance cover and timely remittance of premium insured becomes eligible to following benefit from first day after renewal

(a) Cumulative bonus, if accrued (Ref. Item 9)

(b) Cost of health check-up, if due (Ref. Item 10)

(c) Payment for hospitalisation cost for diseases / illness / injury sustained even during first 30 days of renewal (Ref. Deletion of 4.2 and 4.3)
Renewal of Insurance cover

A further period of 7 days from date of expiry will be permissible in exceptional cases subject to Health Certificate from Medical Practitioner.

(N.B. : Any diseases contracted during the period of 7 days extension will be excluded from the date of renewal in addition to other diseases excluded in the expiring policy, whereas other benefits mentioned above in item 11(a) (b) (c) will be permissible).

It is permissible to extend the Mediclaim Policy to cover the hospitalisation expenses incurred by the insured of Indian origin in Nepal and / or Bhutan while on short visits to these countries. However, the insured would have to make specific request to the operating office for such an extension. Cover may then be granted by attaching an endorsement the draft wordings of which are enclosed. No additional premium will be collected for such extension.

12. **Payment of Premium** : As per Table attached

13. **Cancellation Clause** : The policy may be renewed by mutual consent. The company shall not however be bound to give notice that it is due for renewal and the Company may at any time cancel this policy by sending the Insured 30 days notice by registered letter at the Insured’s last known address and in such event the Company shall refund to the Insured a pro-rata premium for unexpired period of Insurance. The company shall however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the company shall allow refund of premium at company’s short period rate only (table given herebelow) provided no claim has occurred up to the date of cancellation.
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<th>PERIOD ON RISK</th>
<th>RATE OF PREMIUM TO BE CHARGED</th>
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<tr>
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<td>Upto three months</td>
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<td>Upto six months</td>
<td>¾ th of the annual rate</td>
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<tr>
<td>Exceeding six months</td>
<td>full annual rate.</td>
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This prospectus shall form part of your proposal form. Hence please sign that you have noted the contents.

Signature
Name
Place
Date
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</table>
APPENDIX - III

INTERVIEW SCHEDULE TO ELICIT INFORMATION FROM MEDICLAIM INSURANCE BENEFICIARIES IN CHENNAI CITY

SCHEDULE - 1

GENERAL INFORMATION

1. Name : 

2. Sex Male [ ] Female [ ]

3. Age 


5. Extended family [ ] Nuclear family [ ]

6. Members in the family 
   No. of sons : 
   No. of daughters :

7. Monthly income of the policyholders :
   Less than Rs.10,000 [ ]
   Rs.10,0001 - Rs. 15,000 [ ]
   Rs.15,001 - Rs. 20,000 [ ]
   Rs.20,001 - Rs. 25,000 [ ]
   More than Rs. 25,000 [ ]
8. Age of the Policy holders

Less than 25  
26 - 35  
36- 45  
46- 55  
More than 55  

9. Educational status of the Policy holders

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Educational Status</th>
<th>No. of Policy holders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Primary School</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>High School</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>College</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Professional</td>
<td></td>
</tr>
</tbody>
</table>

10. Employment particulars of the policy holders

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Occupation</th>
<th>No. of Policy holders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Business</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Private Employees</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Government Employees</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

11. Health Records of the Policy holders

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Members of the Policy</th>
<th>Place of treatment</th>
<th>Nature of the health problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hospital</td>
<td>Domiciliary</td>
</tr>
<tr>
<td>1.</td>
<td>Husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Wife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Father/Father-in-law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Mother/Mother-in-law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Daughter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE II

UTILISATION OF MEDICLAIM INSURANCE SERVICES

A. INTRODUCTION TO THE SERVICES

12. Have you insured on your own
   Yes ☐ No ☐

13. If No, who inspired you to go in for mediclaim policy
   Government Agents ☐ Media ☐
   Advertisement ☐ Friends ☐

14. Were you compelled to go in for insurance
    Yes ☐ No ☐

15. If yes, then who
    Government
    Employer if working in corporate body or other organisations ☐
    Friends/ Relatives

B. PREMIUM PATTERN AND FACILITIES AVAILABLE

16. What type of mediclaim policy have you taken?
   Individual policy
   Group Policy
   If group, whether Voluntary group
                    Through Company

17. Total sum insured
    Less than Rs.1 lakh ☐
    Rs. 1 lakh - 2 lakh ☐
    Rs. 2 lakh - 3 lakh ☐
    Rs. 3 lakh - 4 lakh ☐
    More than Rs.4 lakh ☐
18. What is the annual premium amount paid?
   Less than Rs.1500             
   Rs.1501 - Rs.3000           
   Rs.3001 - Rs.4500           
   More than Rs.4500           

19. Have you been taking mediclaim policy continuously?
   Yes    No

20. If yes, for how long?
   Number of years

21. Have you availed the discount in premium amount?
   Yes    No

22. Were you eligible for bonus
   Yes    No

23. Have you availed any claim
   Yes    No

24. If yes, how much was the reimbursement?
   Less than Rs.40000           
   Rs.40001 - Rs.50000          
   Rs. 50001 - Rs.60000         
   Rs. 60001 - Rs.70000         
   More than 70000              

C. HURDLES FACED - CLAIM REJECTION & TIME LAG

25. Was your claim rejected by the insurance company.
   Yes    No

26. If yes, why?
   1. Bills not appropriate
   2. Pre-existing diseases
   3. Diseases coming under exclusion List
   4. Some illness claimed twice
27. When the insurance company rejected the claims, what step did you resort to?
Representation to higher authorities ☐
Consumer forums ☐
Third Party ☐

28. Did you include additional members after the policy was taken
Yes ☐ No ☐

29. What was the time lag between the claim made & actual settlement by Insurance Company
1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐

30. What type of funding did you adopt when settlement was delayed
Own funds ☐ Loans from friends / relatives ☐
Pledge Jewelery ☐ Loans from money lender ☐
Pledge property ☐

31. What type of stress did you undergo
No stress ☐ Emotional ☐
Financial ☐ Others ☐

D. RESTRICTIONS IMPOSED DURING SETTLEMENT

32. Was there any restriction imposed on you by the insurance company on total expenditure?
Yes ☐ No ☐

33. If yes - what was the alternative Method of funding you resorted to?

34. Have you opted for maternity benefit for your family members (daughter / daughter-in-law, wife)
Yes ☐ No ☐

35. If No, did you claim reimbursement for this maternity benefit.
Yes ☐ No ☐

36. Have you claimed full reimbursement for elderly members (above 75 yrs) in your family.
Yes ☐ No ☐
37. If yes, did you get the full reimbursement
   Yes ☐      No ☐

SCHEDULE III

POLICY HOLDERS OPINION ON THE WORKING OF MEDICLAIM POLICY

38. Do you feel that the terms and conditions of mediclaim policy are rigid.
    Yes ☐         No ☐

39. a) If yes, why?
    b) If No, why?

40. Do you recommend this mediclaim policy to other people
    Yes ☐         No ☐

41. Do you suggest any changes in the rules of the mediclaim policy
    Yes ☐         No ☐

42. If yes, please furnish the details.

43. Do you feel that disease coming under exclusion list to be covered by this policy?
    Yes ☐         No ☐

44. If yes, please mention the disease

45. Any suggestions for effective implementation of mediclaim policy.