Frequently Asked Questions

Policy Coverage & Eligibility

1. **What is my coverage amount/sum insured under the policy?**
   Company sponsored cover of INR 5,00,000/- floater sum insured.
   Additionally, you may opt for voluntary top-up (premium is deducted from your pay cycles)

2. **Who are our insurance partners?**
   - Insurance Company: Universal Sompo General Insurance
   - Third Party Administrator (TPA): Medi Assist Insurance TPA
   - Broker: Lockton India Insurance Broking and Advisory Ltd

3. **When does my insurance cover start?**
   The annual insurance policy cover for both **Base** (company sponsored) and **Voluntary Top-Up** starts on June 22, 2025. All existing employees who have joined before 21st June 2025 are already insured. For employees joining post June 22, 2025, insurance cover would be insured after your enrolment process is completed as per Fractal Analytics HC Policy.

4. **When does my Insurance Cover end?**
   Both the Insurance policy covers, **Base** (company sponsored) and **Voluntary Top-Up** ends on June 21, 2026, or any of the following events whichever occurs earlier.
   - Termination or expiration of insurance policy on June 21, 2026 (in case of expiry, it would be renewed)
   - Your separation from Fractal Analytics (Last date of employment)
   - As the employee insurance is extended to the dependents, the date of termination of cover for employees is also the date of termination of cover for dependents. Dependent cover will also be terminated if the employee is no longer eligible for such coverage.

5. **What is a floater cover?**
   A floater cover is common insurance coverage for a set of people. In your case, this common coverage is offered to family members, which means that any member from the family unit can utilize the cover up to the total limit.

6. **Who can all be covered under this policy?**
   You can cover your Spouse/Live-in Partner, 3 Dependent Children & 2 Dependent Parents or Parents-In- Laws under this policy. (Cross selection allowed only in case one of the parents is deceased, subject to submission of the death certificate of the deceased one.)

   Please Note: Dependents like Brother, Sister, Uncle, Aunt, or your Grand-Parents cannot be covered in this policy.

7. **What are the age eligibility criteria to cover family members?**
   Dependent children up to the age of 25 years & other members up to the age of 100 years can be covered under this plan. Physically/mentally handicapped dependent child above specified age limit for children will be covered.

8. **Can partners be covered irrespective of the marital status and gender?**
   Yes, you can cover legally wedded/live in partner irrespective of the gender by submitting proof of marriage or proof co-living by means of rent/ownership agreements supporting declaration from the corporate.

9. **Is there any provision to cover adopted children under the insurance policy?**
   Yes, if legally adopted then the dependent can be added to the family floater plan. Adoption agreement to be submitted specifying the legal addition of the dependent to the employee's family.

10. **How do I know that my dependents and I are insured?**
    - After your enrolment, you will get the confirmation mail from Lockton & post endorsement complete family members E-cards will be updated.
    - In case If you have not received the mail acknowledge for enrolment summary, kindly send a mail request to fractalgroup.ind@lockton.com

11. **Do I need to intimate insurer about enrolment of new family members?**
    Newly married or inclusion of new-born in case of delivery?
    Yes, to get the insurance cover for your new dependents from day one of the incidence i.e. marriage date for addition of spouse or of his/her birth in case of new-born baby, you MUST enroll within 30 days from the date of marriage / birth. You can enroll your new dependents on the Lockton portal.

12. **How do I complete the enrolment process for a new-born baby/newlywed spouse?**
    You can mail the details of your new-born and newly wedded spouse on fractalgroup.ind@lockton.com within 30 days from the date of birth to get him/her endorsed in the policy.

Policy Benefits

13. **What are the benefits under this Policy?**
    - Pre-existing diseases are covered from day one, without any waiting periods.
    - Waiver of the 1,2, 3 & 4 Year exclusions and 30 Days waiting period.
    - Pre and post hospitalization expenses are payable for 60 and 90 days respectively.
    - Maternity Benefit coverage from day one, with a limit of INR 75,000/- for Normal and INR 1,25,000/- for C – Section delivery.
    - Infertility Treatment is covered up to INR 75,000/- (Normal Delivery Sub Limit).
    - Maternity Waiting Period of 9 Months is waived off.
    - New born baby is covered from day 1 within the family floater sum insured (Intimation to be sent about expected date of delivery or about childbirth, within 30 days from the date of birth).
    - Surrogacy is covered only for first child maternity expenses of surrogate mother up to maternity sublimit. (No pre-post-natal expenses covered). Covered under family definition if legally binded with family.
    - Pre and post-natal is covered up to INR 5,000 within maternity sublimit for IPD /OPD basis.
    - Room rent and nursing charges are paid as per the actuals for Normal & ICU (Room rent link charges will not be applicable).
    - Internal Congenital ailments are covered.
    - External Congenital ailments are covered in case if life threatening.
    - Ambulance charges paid up to INR 7,500/-, Cardiac Ambulance paid up to INR 12,000/- in emergency cases, per event.

- Air Ambulance/Emergency Air Evacuation covered INR 10,00,000/- for the entire policy period with no limit on utilization.
- Coverage of HIV & AIDS is covered in case of both hospitalization and OPD.
- HPV vaccine for females -Covered up to INR 10,000/- for vaccine, 1 female per family, Total of INR 5 lacs capped per year for all entities.
- Gender affirming surgery covers Cosmetic & Hormone Replacement Therapy (HRT). Insurer shall accept first 5 cases only.
- Cataract covered up to a limit of INR 50,000 per eye.
- AYUSH Expenses are admissible up to 25% of the base sum insured (conditions below)
- Modern Treatment covered up to 100% of the base sum insured on IPD basis
- Hospitalization due to terrorism is covered.
- Physically/Mentally handicapped dependent child above specified age limit for children will be covered.
- Domiciliary hospitalization is covered (conditions below).
- Co-pay is not applicable.

14. What are the broad benefits under Hospitalization Benefit Plan?

Self and your insured family members would get paid for expenses incurred due to any hospitalization. Hospitalization covers various components of expenses like Stay Charges, Operation Charges, Doctor's Fees, Nursing Charges, Investigations & Diagnostics Charges and Medicines etc. The hospitalization must fulfil the following conditions:

- Total stay in hospital should be more than 24 hours (Not applicable for those procedures where the stay in the hospital is reduced due to advancement of medical technology)
- Hospitalization is applicable for treatment of a disease or illness and the treatment given could not have been administered on Outpatient basis.
- Hospitals should have more than 15 beds in Metro Cities OR is registered with the local authorities (this condition is relaxed to 10 beds for non-metro cities).

15. What are the additional benefits under this Plan?

In addition to the expenses being paid for the main hospitalization

- You also get reimbursement of related expenses incurred for same disease / illness 60 days before the Date of Admission to Hospital (Called Pre-Hospitalization Expenses). This could be the doctor's fees, preliminary investigations & diagnostics, and the medicine charges.
- You also get reimbursement of expenses incurred for same disease / illness 90 days after the Date of Discharge from the hospital (Called Post- Hospitalization Expenses excluding Maternity). This could be follow-up consultation with doctor, Medicines, & confirmatory diagnostics etc.

16. Is HPV vaccine covered under the policy?

Yes, HPV vaccine for females are covered up to INR 10,000/- for vaccine, 1 female member per family, (Total of INR 5lacs capped per year for all entities)

17. Are Domiciliary Hospitalization expenses covered?

Yes, our policy covers domiciliary hospitalization expenses.

Domiciliary means medical treatment for an illness/injury which in the normal course would require care and treatment at hospital but is taken while confined at home under any of the following circumstances:

A) The condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
B) The patient takes treatment at home on account of the non-availability of room in a hospital.

18. Does our policy cover Modern Treatments?

The following procedure will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit of **100% of base sum insured against each procedure during the policy period.**

a. Uterine Artery Embolization and HIFU
b. Ballon Sinuplasty
c. Deep Brain Stimulation
d. Oral Chemotherapy
e. Immunotherapy – Monoclonal Antibody to be given as injection.
f. Intravitreal injections
g. Robotic Surgeries
h. Stereotactic Radio Surgeries
i. Bronchial Thermoplasty
j. Vaporisation of the prostrate (Green Laser treatment or holmium laser treatment)
k. IONM- (intra Operative Neuro Monitoring)
l. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

19. Does our policy cover surrogacy expenses?

- Cost of surrogacy (maternity expenses only) can be reimbursed up to maternity sublimit as applicable.
- Only first child maternity expenses of surrogate mothers will be covered (No pre-natal & post-natal expenses will be paid)
- A surrogate child if legally bonded in employee's family can be covered under the policy.

20. Can I claim for expenses incurred in Hospitalization for Miscarriage/Abortion?

Yes, you can. Miscarriage/Abortion claims can be filed & will be paid under maternity limit. However, please note that Voluntary Termination of pregnancy is not payable.

Voluntary Top-Up

21. What are the available voluntary top-up sum insured options and their corresponding premium amounts?

Top-Up Sum Insured Per Family	Top-Up Premium (Including 18% GST)
INR 5,00,000	INR 40,210
INR 10,00,000	INR 47,205
INR 15,00,000	INR 57,669

- The Top-up policy will come into effect only after the Base Policy Sum insured Amount is exhausted.
- The Top-up premium is deducted from your pay cycles.
- Since this is a voluntary policy, the employee will be charged the premium once the enrolment drive is closed.
- Top-up coverage is allowed if a minimum of 15% of Fractalities choose to increase their coverage voluntarily.

22. What are the applicable terms and conditions for the voluntary top-up coverage?

- The eligibility and coverage criteria for the top-up policy will remain the same as the base policy.
- All the terms & benefits applicable to the base policy will continue for the top-up policy except restricted ailment or treatment. This will not be covered under the top-up policy; however, it would be payable under base policy as per the terms and conditions.

23. What are the key reasons to opt for voluntary top-up?

- Higher Coverage at Low Cost: Top-up policies allow you to increase your insurance coverage beyond the base sum insured cover at a much lower premium than individual/retail plans. Your organization negotiates better rates with insurers which are highly competitive, passing the savings to you.
- Covers Large Medical Expenses: Useful for major surgeries or prolonged hospitalizations eliminating out-of-pocket expenses at the time of treatment, thus reducing financial burden.
- Improved Coverage Continuity: Your top-up kicks in automatically when the base cover is exhausted-no extra steps needed. This ensures continuous protection without gaps
- Tax Benefits: Premiums paid by you for the top-up portion are eligible for tax deduction under Section 80D

Hospitalization

24. How do I avail this Hospitalization benefit?

This benefit can be availed in two ways:

Cashless

This insurance plan is administered by Third Party Administrator-Medi Assist. They have a network of hospitals all over India where your insured dependents can get hospitalized & take the treatment without paying the eligible expenses upfront from your pocket. (Applicable for medical expenses only. For non-medical expenses, you must make the payment as per hospital policy.) Cashless hospitalization is allowed only in hospitals that are part of the network hospital list.

Reimbursement

In this traditional form, after your insured dependent's hospitalization is complete; you need to make the payment for these expenses & then get the eligible amount reimbursed from the Insurance Company. Reimbursement of claim documents should be uploaded and submitted within 15 days from date of discharge.

25. What is the process to avail cashless facility?

- Identify whether the hospital is a part of the Third-Party (TPA) Network List.
- If Yes, Obtain Cashless Request Form from the Insurance Desk of the hospital
- Fill in the form with details like your name, TPA ID No., Relationship etc.
- The hospital will fill in details like Date of Admission & Discharge, Ailment, Treatment Plan, Estimated Expenses & send the Fax to TPA.
- TPA will scrutinize the request & send the Approval / Rejection / Query Request to Hospital.
- At this stage, if you need any support, please get in touch with TPA Coordinators.
- Patients can get admitted & treatment can start.
- If the actual bill is more than the approved amount, additional approval is required.
- Ask hospital to fax the Discharge card & Final Bill at least 4 hours before the discharge & get additional approval from TPA.
- On discharge, sign bill & claim form, pay non-medical charges, Co-pay etc.

Note: *Employee (or dependents attending the patient), after the hospital has faxed the Pre-authorization request, can call the Cashless Coordination Helpline of Medi Assist TPA & inform about the request. TPA desk of Medi Assist TPA will identify issues, if any, & will resolve the same after interaction with member at hospital or hospital staff to ensure smooth & timely approval of request.*

Turn Around Time for cashless approvals is 2 hrs. If you do not receive approval within 2 hrs. You can reach out to the escalation contacts for assistance.

26. What happens if I must be hospitalized in case of emergency, for e.g.in case of an accident?

In case of such emergency events –

- Please take the patient to the nearest good hospital & start the treatment.
- Let the patient stabilize.
- Follow the standard procedure for Cashless Authorization in case of network hospital and Reimbursement in case of non-network hospital.

27. What if reimbursement is opted in Network hospital?

Network hospitals grant discounts on final bills as per their tie-up with TPA and Insurance company.

(Excluding package rates).
However, in case a member is admitted to a network hospital and opts for reimbursement, hospital discounts will not be applicable and will be charged to the member.

Claims Process

28. How do I claim the amount if the hospitalization is in non-network hospital?

The first thing you have submit for reimbursement for your claim,

- You must collect all the original documents from the treated hospital & upload the original documents soft copies as per the document checklist within 15 days from the date of discharge
- Kindly mention the name of the insurer on the documents.
- If there is no shortfall in the documents you should get the settlement within 21 working days from the date of submission of your claim or the date of fulfilling all the additional documents, whichever is later.
- Additional documents (deficiency documents) if any needs to be uploaded within 7 days from the date of first intimation of the additional required documents.

29. What happens if a reimbursement claim is registered under the network work hospital of Medi Assist TPA?

Employees must opt for a cashless option if they are going to a network hospital. In the event you are not opting for a cashless feature in a network hospital, this has an impact on the hospital discount. Network hospitals grant discounts on final bills as per their tie-up with TPA and Insurance companies (excluding package rates). However, in case a member is admitted to a network hospital and opts for reimbursement, a hospital discount will not be applicable and will be charged to the member. This is to encourage employees to opt for cashless in-network hospitals where the cashless facility is available.

Example: If your admissible claim is INR 25,000. In addition to this, if the hospital has given a discount to the TPA on account of a tie-up of INR 2000, you will be eligible to get a claim from the Insurance Company of INR 23,000. (Claim Amount of INR 25,000 – INR 2,000 Hospital Discount). Hospital Discount will be charged to you.

Mandatory Documentation

30. What are the mandatory documents required for registering a reimbursement claim?

Following is the list of documents. Please note that all documents should be ORIGINAL soft copies.

- **Claim Form**
  Part A: All details must be filled in & should be signed by the EMPLOYEE only.
  Part B: To be filled by the hospital with signature and stamp.
- **Discharge Card**
  It contains details like Date of Admission & discharge, patient's condition while getting hospitalized, brief diagnosis & treatment administered at hospital & doctor's advice on discharge.
- **Letter of 1st Consultation and advice for hospitalization.**
  This is the document which your doctor advises you to get hospitalized for medical treatment of disease or a Surgical Procedure. It should be on the letterhead of the Doctor & should mention the date.
- **Proper Hospital Bills with Receipts Duly Stamped & Signed.**
  This is the most important document & in absence of it, no payment can be made. The bill should be detailed. Also insist that the Registration No. of the hospital is mentioned on the bill. The receipt for the payments made should be pre-numbered and preferably Pre-printed.
- **Medicine Bills with Doctor's prescriptions for the same**
  Each medicine bill must have date on it & should bear the patient's name too. In case of Psychiatric/psychosomatic claims, photocopy of prescriptions is mandatory.
- **Investigation Reports, Bill Receipts & Treating doctor 's advice letter for all the tests performed.**
  For all the tests conducted, the same MUST be advised by the doctor. A receipt of payment should be produced & the report should be submitted. Please do not send any X-Ray films. Only a report by competent doctor is good enough. In case of X-ray film required, same will be communicated separately.
- **Consultation Papers & Receipts**
  This is the proof of payment made to doctor for consultations. As these payments are small in terms of denominations, we often forget to get these receipts & lose on the payments. Please insist on receipt every time you visit the doctor for consultation.
- **Photo ID proof & address proof of claimant (patient)**
  Reimbursement claims, which are above INR 1 lac, please attach Photo ID proof & address proof of patient.
- **Cancelled Cheque**
  Submit the physical copy of cancelled cheque for your bank account with account holder name, IFSC code.

Disclaimer: At the time of claim processing, TPA officials may require additional documents, in case submitted documents are not enough for claim processing. The insurer may request additional documents on a case-by-case basis.

31. What are the mandatory documents required for a partial claim?

- The claim form part A to be filled by the employee.
- Attested copy of all the documents submitted to the other insurance company or TPA along with the original settlement letter.
- Original balance paid cash receipt if any.
- Personalized cancelled cheque.

32. What are the mandatory documents required for a maternity claim?

The following is a list of specific claim documents to be submitted along with general documents:

- Gravida (GPLA) Status: The number of living children's details to be specified by the treating doctor.
- Newborn Baby: In case of a newborn baby hospitalization, do submit a separate claim for the baby with a separate claim form.

33. What are the mandatory documents required for a cataract claim?

The following is a list of specific claim documents to be submitted along with general documents:

- IOL (Intra-Ocular Lens) Sticker- This sticker indicates the Make & Model of the lens along with its Serial No. This is proof that Cataract surgery was performed & an IOL is implanted
- Biometry Test /A-scan Report
- An investigation report indicates the measurement of power of cornia.
- Tax Invoice for IOL is Mandatory
- Since the IOL is not included in the hospital bill and is billed separately, a tax invoice is necessary to clarify the cost of the IOL.

34. What are the mandatory documents required for HPV Vaccination and the process to claim?

HPV vaccine expenses are reimbursed. Please follow general reimbursement procedures to claim the expenses. Below is the list of documents you need to furnish and upload along with the general documents of reimbursements.

- Claim Form A
- Claim Form B
- Vaccine Documents
- Vaccine Bill
- Amount Paid Receipt

35. What are the mandatory documents required for an accident claim?

The following is a list of specific claim documents to be submitted along with general documents:

- FIR (First Information Report) / MLC (Medico-Legal Certificate)
- A copy of FIR (First Information Report) filed with the nearest Police Station informing them about the accident. MLC (Medico Legal Certificate) registered (for accident/ assault/ poisoning/ burn cases) by hospital authorities and submitted to the local police station.
- Non-Alcohol Certificate
- If the claimant is the driver in an accident case, a certificate from a doctor indicating that the patient was not under the influence of alcohol while getting admitted to the hospital is required. This can also be mentioned on the Discharge Card

36. What are the mandatory documents required for a death claim?

The following is a list of specific claim documents to be submitted along with general documents:

- Death Certificate
- This certificate is issued by the local Municipal Authority or any local authority.
- Death Summary
- In cases where the patient has deceased, a Discharge Certificate is not issued. Instead, a Death Summary is provided, which outlines the patient's condition and the cause of death while in the hospital. This document is essential for the processing of death claims.

Standard Exclusions & Other Queries

37. What are the Standard exclusions of this policy?

Any medical expenses incurred for or arising out of:

- War invasion, Act of foreign enemy, War like operations, nuclear weapons, ionizing radiation, contamination by radio activity, by any nuclear fuel or nuclear waste or from the combustion of nuclear fuel.
- Circumcision, cosmetic or aesthetic treatment, plastic surgery unless required to treat injury or illness.
- Vaccination & Inoculation.
- Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.
- All types of Dental treatments except arising out of an accident.
- Convalescence, general debility, 'Run-down' condition or rest cure, obesity treatment and its complications, congenital external disease/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, sterility, use of intoxicating drugs/alcohol, use of tobacco leading to cancer.
- Bodily injury or sickness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, attempted suicide, arising out of non-adherence to medical advice.
- Treatment of any Bodily injury sustained whilst or as a result of active participation in any hazardous sports of any kind.
- Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act.
- Sexually transmitted diseases, any condition directly or indirectly caused due to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB-III) or lymphography Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.
- Diagnosis, X-Ray or Laboratory examination not consistent with or incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
- Vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.
- Naturopathy Treatment.
- Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.
- Genetic disorders.
- Treatment taken outside India.
- Unproven / Experimental Treatment.
- Change of treatment from one system to another unless recommended by the consultant / Hospital under whom the treatment is taken.
- Any kind of service charge, surcharge, admission fees or registration charges levied by the hospital.
- Treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- Other Standard exclusions are specific to the insurance company.

38. What happens if the details like DOB, Name furnished by me while enrolling are incorrect?

- It is important that you provide correct information as per government photo id proof.
- In case of discrepancy in data available & the actual data furnished (for example: you may have mentioned in the online form your mother's age as 48 years and the claim form & hospital records have mentioned it as 58 years), your claim may get rejected.
- Mismatch in age, name may lead to denial of claim as the insurance is a contract based on the concept of "UTMOST GOOD FAITH" between the insurer and insured.

39. I, along with my spouse, work with Fractal. My delivery is due in couple of months, how much Maternity benefit can I avail? Will it be INR 75,000/- or double the amount i.e. INR 75,000/- through my husband's coverage & INR 75,000/- from my own coverage?

No, it would be INR 75,000/- only.

40. I work in Fractal & my spouse works in some other organization. My spouse's delivery is due in a couple of months. How can I make a reimbursement claim as my wife also has group Mediclaim policy from her organization?

You can claim the maternity expenses under the **Fractal** policy up to the limit of INR 75,000/-. If actual expenses incurred by you are more than this limit, then you can get reimbursement for the same from your spouse policy. (Subject to terms and condition of Mediclaim policy of your spouse policy).

41. What is Portability? How is it beneficial to me?

Portability is a facility extended by IRDAI (Insurance Regulatory Development Authority of India - The Insurance sector regulator in India) to help the insured member carry the time credit of their insurance plan when they exit such a plan.

For example, if you & your dependents are insured under the Fractal Group plan since last 4 years & you decide to separate and start your own business. At such time, your Fractal Group insurance cover will cease to exist & you have to buy a fresh retail insurance plan which will typically have restrictions like 30 Days waiting period, 1st & 2nd Year Exclusion & Pre-existing diseases cover only after 4 years of cool off period. This would be very restrictive & hence, some of your claims would not be paid for due to these conditions. However, if you port your insurance plan, you will get waiver for all these conditions as you already have a 4-year insurance credit history.

42. I am putting in my papers. Whom shall I get in touch with to avail portability?

- You shall receive detailed instructions when you receive various forms as part of your relieving Handing Over procedure. One of the parts would be instructions on portability.
- Please note that the initiation of portability must be done at least 45 working days before the date of separation by an employee through an email to HR along with details like your Date of Joining, Date of Separation, Alternate Mobile No, & Alternate E mail ID.
- When opting for portability, insurers often require claim utilization history from the previous TPA or in-house TPA for all the years the employee or family members were covered under previous corporate health insurance policies.
- This information shall then be shared with the Lockton Team. They will help you in getting the necessary insurance credit certificate as well as getting the new insurance cover started for you, based on the receipt of an appropriate premium from you.

43. Who should I contact, in case of any further queries regarding the plan?

You can contact Medi Assist TPA & Lockton Insurance Broking Services Pvt. Ltd, for any queries regarding this Health Plan. Please get in touch with them for any of the following issues.

- Checking whether enrolment is done or not
- Getting your Health E-Card
- In case of delay or problems in getting cashless
- In case of delay or problems in getting the reimbursement claim
- Changes in the enrolment information
- Any other queries regarding this Health Plan.

TPA & Broker Contact Matrix

Cashless & Reimbursement Claims			
Level	**Name**	**E-mail ID**	**Contact Number**
Level 1	Mr Roopesh R	roopesh.r@mediassist.in	+91 6364932161
Level 2	Mr Arjun Sharma	arjun.sharma@mediassist.in	+91 7338467567
Level 3	Mr Priyank Gupta	priyank.gupta@mediassist.in	+91 8147369817
Level 4	Mr Prem Kumar	fractalgroup.ind@lockton.com	+91 8197219003
Enrolment Queries			
Level		**E-mail ID**	**Contact Number**
Mr Prem Kumar		fractalgroup.ind@lockton.com	+91 8197219003
Final Escalation			
Level		**E-mail ID**	
Mr Manjunath TR		manjunath.tr@lockton.com	