### REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

### DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a.	Name of TPA / Insurance company:	IDAL HEALTH INSURANCE TPA PRIVATE LTD.
b.	Toll free phone number:	
C.	Toll free fax:	
d.	Name of Hospital:	
	i. Address	
	ii. Rohini id	
	iii. e-mail id	
	TO BE FILLED	BY INSURED/PATIENT
A.	Name of the Patient :	
B.	Gender:	Male Female Third Gender
C.	Age:	/ (Years) / (Month)
D.	Date of Birth:	(DD/MM/YYYY)
E.	Contact number:	
F.	Contact number of attending Relative:	
G.	Insured Card ID number:	
Н.	Policy number / Name of Corporate:	1
I.	Employee ID:	
J.	Currently do you have any other mediclaim /	health insurance: Yes No
	i. Company Name:	
	ii. Give Details	
K.	Do you have a family Physician:	Yes No
L.	Name of the Family Physician:	
M.	Contact number, if any:	
N.	Current Address of Insured patient:	
Ο.	Occupation of Insured patient:	(PLEASE COMPLETE DECLARATION OF THIS FORM)

### TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A.	Name	e of the treating Doctor:					
B.	Conta	act number:					
C.	Natur	re of Illness / Disease with presenting of	complaint:				
D.	Relev	vant Critical Findings:					
E.	Durat	tion of the present ailment:		Days			
	i.	Date of First consultation:				(DD/MM/YY	YY)
	ii.	Past history of present ailment, if an	у				
F.	Provi	sional diagnosis:					
	i.	ICD 10 code					
G.	Propo	osed line of treatment:					
	i.	Medical Management	(	)			
	ii.	Surgical Management	(	)			
	ii.	Intensive care	(	)			
	iv.	Investigation	(	)			
	V.	Non-allopathic treatment	(	)			
H.	If inv	estigation and / or Medical Manageme	nt, provide det	ails			
	i.	Route of Drug Administration :					
I.	lf sur	rgical, name of surgery					
	i.	ICD I0 PCS code					
J.	If oth	ner treatment, provide details					
K.	How	did injury occur					
L.	In ca	se of accident					
	i.	Is it RTA:				Yes	No
	ii.	Date of Injury:				(DD/MM/YY	YY)
	iii.	Report to Police				Yes	No
	iv.	FIR NO:					
	٧.	Injury / Disease caused due to subs	stance abuse /	alcohol consumpt	tion	Yes	No No
	vi.	Test conducted to establish this (if y	/es, attach rep	ort)		Yes	No
M.	In ca	se of Maternity		G	P	L	
	i.	expected date of Delivery				(DD/MM/YYY)	<b>Y</b> )

### **DETAILS OF PATIENT ADMITTED**

	A.	Date of admission	(DD/MM/YYYY
	B.	Time of admission	(HH:MM)
	C.	Is this an emergency / planned hospitalization event:	Emergency Planned
	D.	Mandatory Past History of any chronic illness	if yes (since/)(month/year)
		i. Diabetes	
		ii. Heart disease	1
		iii. Hypertension	1
		iv. Hyperlipidemias	1
		v. Osteoarthritis	1
		vi. Asthma/COPD/Bronchitis	
		vii. Cancer	1
		viii. Alcohol/Drug abuse	1
		iX. Any HIV/ or STD Related ailment	1
		X. Any other ailment, give details	
	E.	Expected number of Days / stay in hospital	Days
	F.	Days in ICU	Days
	G.	Room Type	
	H.	Per day room rent+nursing and service charges+ patients diet	
	I.	Expected cost of investigation + diagnostic	
	J.	ICU charges	
	K.	OT charges	
	L.	Professional fees Surgeon + Anesthetist Fees + consultation Charge	es
	M.	Medicines + Consumables + Cost of Implants (if applicable please s	specify)
	N.	Other hospital expenses if any	
	Ο.	All-inclusive package charges if any applicable	
	P.	Sum Total expected cost of hospitalization	
		<u>DECLARATION</u> (Please read very carefully)	
Ve confir	m having	read understood and agreed to the Declarations of this form	
a.	Name o	of the treating doctor	
b.	Qualific	ation:	
C.	Registra	ation number with State code	
Н	lospital Se	eal	Patient / Insured Name and Sign

(Must include Hospital ID)

### **DECLARATION BY THE PATIENT / REPRESENTATIVE**

- a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer / TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- c. All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer / T.P.A. not governed by the terms and conditions of the policy will be paid by me.
- d. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A.
- e. I agree and understand that T.P.A. is in no way warranting the service of the hospital & that the Insurer / TPA is no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, Suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer / TPA.
- h. "I/We authorize Insurance Company / TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's Name:	
b) Contact Number:	email-ld (optional)
c) Patient's / Insured's Signature:	
Date: Time:	<u></u>

#### **HOSPITAL DECLARATION**

- We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
- c. We agree that TPA / Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
- d. The patient declaration has been signed by the patient or by his representative in our presence.
- We agree to provide clarifications for the queries raised regarding this hospitalization and we take responsibility the sole for any delay in offering clarifications.
- f. We will abide by the terms and conditions agreed in the MOU.
- g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
- h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
- i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and / or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal		Doctor's Signature	
Date:	Time:		









## **NETWORK HOSPITAL - DECLARATION BY PATIENT/PATIENT'S ATTENDANT**

Name of the Hospital :	Date :
Address:	
PATIENT NAME (BLOCK LETTERS) :	AGE/SEX :
IP No : UHID No :	Mobile No of Patient :
Date of Admission : Time of	of Admission :
Date of Discharge : Time of	of Discharge:
Address of the Patient :	
NAME OF THE ATTENDANT :	
Mobile No. of Attendant :	Address :
Declaration regarding Insurance Policy (Strike off  (i) Declaration when patient has no  • I declare that I do not have an	insurance policy:  y insurance policy.
(ii) Declaration when patient has ins	
<ul> <li>I declare that I have following</li> </ul>	Insurance Policies
Policy No/TPA card No:	
Insurance Company:	
2) Whether patient opted for Eligible Room Car Yes / No	tegory under Policy:
3) In case, policyholder wishes to avail better	facility:
Name of the Additional Facility/ Provision/ P	rocedure/ Treatment
	which costs Rs :
	) only.
being explained in detail by the Hospital authorabove mentioned Additional Facility/Procedurabove the agreed tariff. Further, if I opt to go	er facility and I hereby agree to pay on my free will, after prity in my own and understandable language about the re/Treatment and associated cost of it, which is over and for final bill reimbursement with insurance company, only as per agreed tariff rates and balance amount will be
	ervice of a category better than eligible room rent is availed in rent but also an equal proportion of all other charges by me.
Signature :	Signature :

### CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

#### Important Instructions:

- A) Fields marked with '\*' are mandatory fields.
- B) Self-Certification of documents is mandatory
- C) Please fill the form in English and in BLOCK letters.
- D) Please fill the date in DD-MM-YYYY format.
- E) Please read section wise detailed guidelines / instructions at the end.
- F) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
- G) List of two character ISO 3166 country codes is available at the end.
- H) KYC number of applicant is mandatory for update application.
- For particular section update, please tick (✓) in the box available before the section number and strike off the sections not required to be updated.



For office use only	Application Type*	□New	☐ Update	Account Type*	□ Normal	Small
(To be filled by financial institu	tion) KYC Number				(Mandatory for KYC up	date request)
☐ 1. PERSONAL DETAIL	LS (Please refer instruction	A at the end	)			
	Prefix F	irst Name		Middle Nam	ne	Last Name
☐ Name* (Same as ID proof)						
Maiden Name (If any*)						
Father / Spouse Name*						
Mother Name*						
Date of Birth*		YY				РНОТО
Gender*	☐ M- Male		☐ F- Female	☐ T-Trans	gender	
Marital Status*	☐ Married		Unmarried	☐ Others		
Nationality*	☐ IN- Indian		☐ Others (ISO 3	3166 Country Co	ode )	
Residential Status*	☐ Resident Individual		☐ Non Resident	Indian		
<del>-</del>	☐ Foreign National		☐ Person of India			
Occupation Type*	☐ S-Service ( ☐ Privat	e Sector	☐ Public Sector	Governme	ent Sector )	
	☐ O-Others (☐ Profes	ssional	☐ Self Employed		☐Housewife ☐Studer	<i>'</i>
	<ul><li>□ B-Business</li><li>□ X- Not Categorised</li></ul>					
	X- Not Categorised					
☐ 2. TICK IF APPLICAB	LE RESIDENCE FOR	R TAX PURF	POSES IN JURISE	DICTION(S) OU	TSIDE INDIA (Please refe	r instruction <b>B</b> at the end)
ADDITIONAL DETAILS RE	QUIRED* (Mandatory only	if section 2 is	ticked)			
ISO 3166 Country Code of						
Tax Identification Number o						
Place / City of Birth*			ISO 3166 Counti	ry Code of Birth'	*	
☐ 3. PROOF OF IDENTI	TY (Pol)* (Please refer ins	struction <b>C</b> at	the end)			
(Certified copy of <u>any one</u> of the	e following Proof of Identity[F	Pol] needs to	be submitted)			
☐ A- Passport Number		-	,	Passport Exp	oiry Date	M M — Y Y Y Y
☐ B- Voter ID Card						
☐ C- PAN Card						
☐ D- Driving Licence				Driving Licen	ce Expiry Date	
☐ E- UID (Aadhaar)				Driving Licen	CC Expiry Date D D =	
F- NREGA Job Card						
_	notified by the central gover	nment)		Idontifi	ication Number	
2- Outers (any document	nomied by the central gover	milent)		identin	ication intiliber	
4. PROOF OF ADDRE	ESS (PoA)*					
4.1 CURRENT / PERMAN		S DETAILS	(Please see instruct	ion <b>D</b> at the end)		
(Certified copy of <u>any one</u> of the						
Address Type*	Residential / Busines	s $\square$	Residential	Business	☐ Registered Of	fice Unspecified
Proof of Address*	☐ Passport	_	Driving Licence	UID (Aad	· ·	
Addross	☐ Voter Identity Card		NREGA Job Card		please s	pecify
<b>Address</b> Line 1*						
Line 2						
Line 3					City / Town / Village*	
State / U.T Code*	Pin	/ Post Code	*		3166 Country Code*	

4.2 CORRESPONDENCE	4.2 CORRESPONDENCE / LOCAL ADDRESS DETAILS * (Please see instruction <b>E</b> at the end)																								
Same as Current / Perma	☐ Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, please fill 'Annexure A1')																								
Line 1*																				Ш		Ш			
Line 2																			Щ	Щ		Щ	<u> </u>		
Line 3													Ci	ty /	Tow	/n / \	/illa	age*	Ш	_		Ш	$\perp$		
State / U.T Code*			Pin	/ Pos	t Cod	e*						ISC	O 31	66 C	Coui	ntry	Co	de*							
4.3 ADDRESS IN THE JU	RISDICTION	DETAILS	S WH	ERE A	PPLIC	ANT I	S RE	SIDEI	NT O	JTSID	E IND	DIA F	OR	TAX	PUF	RPO	SES	S* (A	pplic	able	if se	ction	2 is	ticke	d)
Same as Current / Perma	nent / Overse	eas Addre	ss de	tails				Sar	ne as	Corre	spon	dend	ce / L	ocal	Add	Iress	det	tails							
Line 1*																				Ш					
Line 2																				Ш			$\perp$		
Line 3												<u></u>	Ci	ty/	Tow	/n / \	/illa	age*						Щ	
State*								ZIP	/ Po	st Co	de*							ISC	31	66	Cou	ntry (	Code	e*	
□ 5 CONTACT DETAILS	5. CONTACT DETAILS (All communications will be sent on provided Mobile no. / Email-ID) (Please refer instruction <b>F</b> at the end)																								
	(All Collination	cations will	1 00 30				ie iio.	Lilla	י (טו-ווו	i icasc	reiei	IIIou	uctio												
Tel. (Off)	-			Te	el. (Re	s)		Ш.					Щ		Mob	oile	Ц	<u> </u>		4		Щ	_		
FAX	-			Е	mail IE	)																Ш			
☐ 6. DETAILS OF RELAT	ED PERSON	(In case	e of ac	dditiona	al relate	d pers	ons, p	lease	fill 'Ar	nexure	B1')	(plea	ase re	efer in	nstru	ction	<b>G</b> a	at the	end)						
Addition of Related Person	Deletion	of Related	l Pers	on			KY	′C Nu	mber	of Rela	ted Pe	ersor	n (if a	availa	able*)	)									
Related Person Type*	☐ Guardia	n of Minc	or	☐ No	minee		Assi	gnee	: [	Autl	norize	ed R	epre	sent	tativ	е		Bei	nefic		Owne			enef	iciary
N1 #	Prefix			First N	ame						Middle	e Na	me								Last	Name	9		
Name*	(If KVC num	ber and no	amo a	ro prov	ided b	olow de	ataile (	of coct	tion 6	are ent	ional)														
(If KYC number and name are provided, below details of section 6 are optional)																									
PROOF OF IDENTITY [Pol] OF RELATED PERSON* (Please see instruction (H) at the end)																									
☐ A- Passport Number										Pa	sspo	rt E	xpiry	/ Da	ite			D D	_	IVI	IVI —	Υ	Y	Υ	
☐ B- Voter ID Card																									
☐ C- PAN Card																									
□ D- Driving Licence										Dri	ving	Lice	ence	Exp	piry	Date	е	D D	_	IVI	M -	Υ	YY	Υ	
☐ E- UID (Aadhaar)																									
☐ F- NREGA Job Card																									
Z- Others (any documen	t notified by t	he centra	l gove	ernmer	nt)						le	den	tifica	ition	Nu	mbe	er			Т		П	$\top$		
☐ 7. REMARKS (If any)																									
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			+									$\pm$		$\pm$	$\pm$			+		$\overline{}$		$\forall$	$\pm$		
8. APPLICANT DECL	ARATION																								
I hereby declare that the details furn	ished above are t	rue and corre	ect to th	e best o	of my/ou	r knowle	dge and	belief	and I	undertak	e to inf	orm y	ou of a	ny											
changes therein, immediately. In cast I/we may be held liable for it.	se any of the abov	e informatior	n is four	nd to be f	alse or u	ntrue or	mislead	ing or m	nisrepre	senting,	I/We ar	n/are	aware	that											
<ul> <li>My personal / KYC details may be</li> <li>I hereby consent to receiving inform</li> </ul>				ah SMS	Email on	the abov	vo rogie	torod n	umbor/e	mail add	troce														
Date: DD - MM -	auon nom centra	rki o ikegisi	Pla		Liliali Oli	THE ADO	ve regis	lereu ni	umben	illali au	11000						Sic	anatur	e / Th	umb	Impres	sion o	of App	licant	
Date . D D III III			Гіа	. <u> </u>														<b>J</b>							
9. ATTESTATION / FO	R OFFICE	USE ON	ILY																						
Documents Received	Self-Certifi	ed 🗆	True	e Copi	es	_ No	tary	Ri	sk C	atego	ry		] Hi	gh			Ме	ediun	n			_ow			
IN PERSON VE	ERIFICATION	CARRIED	OUT	BY					INSTITUTION DETAILS																
Identity Verification	one D	ate 🗇	D —	M M	_ Y	YY	Y	Na	ame																
Emp. Name									ode						+		+			$\pm$		H	+		
Emp. Code								CO	,uc																
Emp. Designation																									
Emp. Branch																									

# **BREACH CANDY HOSPITAL TRUST**

## **CONSENT FORM - CASHLESS CLAIM**

## List of Documents to be carry with the pre-authorization Form

- 1) Fully Filled pre-authorization form (provided by the hospital).
- 2) Pan card & Adhaar card of the Patient.
- 3) Pan card & Adhaar Card of Primary Insured.
- Relevant Investigation Reports.
- 5) Vaild Insurance ID.
- 6) Cancelled Cheque of Patient Account.

### Highlights:

Received by:\_

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval amount of the patient.
- If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form
  then the additional documents will be processed by the TPA desk. If the approval is not received before
  the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid
  as a deposit.
- In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- On the day of discharge once all required documents are sent to the Insurance Co. /TPA, it takes up to 4hrs. for the approval to come. Patientcan be physically discharged only after final approval is received by the hospital.
- At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit
  which will be refunded to the patient after the final settlement from the Insurance Company, the duration
  of which is variable (minimum is 45 days).

Consent:	200		38 ,Ak)					
I am fully aware of the details mentioned in the co-n	norbidities/pre-existing	illness/past history diseases se	ection					
of my insurance claim form filled in by me. If there	is any difference in the i	nformation filled in the claim	form					
as against the past history filled in the Initial Assessr	nent form at the time of	f admission then the hospital	shall					
not be liable for any issues with regards to getting th	e approval from the insu	rance. I will not hold hospita	1					
responsible if the Insurance/TPA denies the entire cla	aim for this reason and	I shall settle the entire bill.						
I declare that I have been explained all the above me	ntioned points and I agr	ee to the same.	1.5					
Patient Name :	BH No	DOA :						
Name & Signature of person submitting Claim Documen								
Date :								
For Office Use Only								

BCHT/TPA/CON/3/01-23

Date & Time :

# **BREACH CANDY HOSPITAL TRUST**

## IMPORTANT INFORMATION REGARDING YOUR CASHLESS CLAIM

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- Admission will be on the basis of the authorization letter received from the TPA/Insurance Company which
  is only a provisional authorization. Please show a copy of this letter on the Admission Desk at the hospital
  at the time of Admission.
- 3. In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- 4. If any query is raised before or during the hospitalization which requires to furnish additional information of the Medical condition of the patient then the clarification will be provided by the Consultant/Surgeon and may be delayed depending upon the availability of the Consultant/Surgeon.
- 5. If the query requires to provide any details which are non-medical in nature the TPA desk will reply to them as soon as possible which may require help from the patient relative.
- 6. At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval of the patient.
- In a single hospitalization one can avail cashless only with one TPA/Insurance Company, if the patient has
  more than one policy they can avail the reimbursement facility. Please contact the TPA Desk for further
  details.
- 8. For knowing the coverage of any particular (Medical/Surgical) condition under your Policy, please read the T&C of your policy document or speak to your agent.
- For Room Eligibility of the patient please contact your agent for criterion of admission as per the policy of the patient.
- 10. If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
- 11. In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- 12. On the day of discharge once we send all required documents to Insurance Co. / TPA, it takes up to 4 hrs. for approval to come. The patient can be physically discharged only after approval comes as per the policy.
- 13. Half day charges will be levied for patients if the discharge process is initiated between 11.00 am to 1.00 pm. All discharges processed after 1.00 pm will attract full day charges.
- 14. The original reports and bill will be handed over to the TPA/Insurance Company for processing of the claim. A copy of all the reports will be available at the reports counter, 7 days after the discharge.
- 15. Acopy of the Discharge Summary will be provided to the patient at the time of discharge.
- 16. At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable (minimum is 45 days).
- 17. Any deductions toward non-medical items, exclusions, class based billing etc. will have to be borne by the patient (this will not be adjusted against the security deposit).
- 18. Please submit a cancelled cheque to get the refund into your account directly.
- 19. In case of denial of the cashless claim (due to withdrawal or rejection of the claim) during the hospitalization or at the time of discharge the patient will be treated as a cash patient and will be expected to clear the entire bill of the hospital and proceed for the reimbursement process.
- 20. Only approval letters received on the Email or the Portal will be considered valid.
- 21. There may be a delay in receiving the approval on Public Holidays or Sundays.

BCHT/TPA/INFO/3/01-23

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- Relevant Investigation Reports.
- 5) Vaild Insurance ID.
- 6) Cancelled Cheque of Patient Account.

### **Highlights:**

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization.
   For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a
  deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and
  the final approval amount of the patient.
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- On the day of discharge once all required documents are sent to the Insurance Co. / TPA, it takes up
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  received by the hospital.
- At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit
  which will be refunded to the patient after the final settlement from the Insurance Company, the
  duration of which is variable (minimum is 45 days).