Where to Submit the claim

INHOUSE Health Claims Processing HUB TATA AIG General Insurance Company Limited, H.No 7-1-6-617/A, 5th and 6th Floor, Imperial Towers, Door No 615,616, Ameerpet, Hyderabad 500016, Telangana.

How to track the claim

Step-1	Open www.tataaig.com and click on Self Service
Step-2	Login & choose search claims
Step-3	Track claim status with the help of Policy Number/Member ID/ Claim Number

Please submit complete documents as per the check list for speedy claim settlement.

CLAIM DOCUMENTS SUBMITTED-CHECK LIST

S.No.	Document	Yes	No	Type of document
1.	Copy of cancelled cheque for the proposer- Account holder's name, account number and IFSC code should be printed on the submitted copy			
2.	If the claimed amount is more than 1 Lakh; CKYC Form along with Photograph + PAN Card Copy of the Proposer + Address Proof			
3.	Claim form _ Please fill all the mandatory fields with appropraite information			
4.	Tata AIG Health Card or Policy Copy			
5.	ID, Address & Age Proof of the patient & Proposer			
6.	Discharge/Daycare Summary from the hospital indicating the presenting complaints, diagnosis, treatment given and Past medical history			
7.	Hospital Finall Bill with breakup of the individual items of the bill			
8.	Proof of payment paid at hospital - cash receipt			
9.	In case of Implants being used - Please share relevant Invoice & Sticker			
10.	Pharmacy & lab Bills			
11.	Diagnostic/lab Reports for submitted bills			
12.	Doctor Prescriptions for submitted pharmacy bills			
13.	Previous medical records and Consulation papers prior to hospitalization			
14.	Any previously approved settlement letter from other insurance (if any)			
15.	In case of accidental injuries, pleas submit Medico Legal Case (MLC) /First Information Rreport (FIR)			
16.	In case of death of main member, details of nominee (as per policy schedule), along withaddress & ID proof of nominee.			
17.	Hospital reigistration certificate			

Type of Claim:

- ☐ In-Patient Treatment
- ☐ Day Care Procedures
- ☐ Health Checkup
- ☐ High End Diagnostics
- ☐ OPD Treatment – Dental
- ☐ Maternity Cover
- ☐ Restore benefits
- ☐ OPD Treatment
- ☐ Daily Cash for choosing Shared Accommodation
- ☐ Pre & Post-Hospitalization expenses

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MediCare Premier New UIN: TATHLIP23167V032223 • **MediCare Old UIN:** TATHLIP21224V022021 • **MediCare New UIN:** TATHLIP23118V032223
MediCareProtect UIN: TATHLIP21225V022021 • **Medicare Plus UIN:** TATHLIP21253V022021

CLAIM FORM

(Part-A)

To be filled in by the insured. The issue of this Form is not to be taken in as admission of liability
Please fill-up this form in CAPITAL LETTERS

DETAILS OF PRIMARY INSURED (*Mandatory fields) (SECTION A)

Policy No*:

Sl. No. Certification No*:

Company Name*: Tata AIG GIC Ltd.

Name*: Prefix | First Name | Middle Name | Last Name

Address*:

Registered E-mail id*

Registered Phone Number* /

DETAILS OF INSURANCE HISTORY (SECTION B)

i. Currently covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

ii. Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐

Date: Diagnosis:

iii. Date of commencement of first insurance without break:

If yes, Company Name:

Policy No: Sum Insured (Rs.):

iv. Previously covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

If yes, Company Name:

Policy No: Sum Insured (Rs.):

DETAILS OF INSURED PERSON HOSPITALIZED (SECTION C)

Name: Prefix | First Name | Middle Name | Last Name

Gender: Date of birth: Age Years Months

Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)

DETAILS OF HOSPITALIZATION (SECTION D)

Name of Hospital: where Admitted

Room Category occupied: ☐ Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

Hospitalizaton due to: ☐ Injury ☐ Illness ☐ Maternity

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Date of injury/Date Disease first detected/Date of Delivery : ☐☐☐☐☐☐☐☐

Date of Admission: ☐☐☐☐☐☐☐☐ Time: ☐☐☐☐

Date of Discharge: ☐☐☐☐☐☐☐☐ Time: ☐☐☐☐

If Injury give cause: ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

If Medico legal: Yes ☐ No ☐

Reported to police: Yes ☐ No ☐

MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine ______________________________

DETAILS OF CLAIM (SECTION E)

Details of the treatment expenses claimed:		Details of Lump sum/cash benefit claimed:	
Type of claims	**Total expenses**	**Type of claims**	**Total expenses**
In-Patient Treatment		Critical Illness	
Pre & Post-Hospitalization expenses		Accidental death benefits	
Day Care Procedures			
Health Checkup			
Daily Cash for choosing Shared Accommodation			
OPD Treatment			
OPD Treatment – Dental			
Maternity Cover			
High End Diagnostics			
		Grand Total	

DETAILS OF BILLS ENCLOSED: (SECTION F)

Sl. No.	Bill No.	Date	Issued by	Towards	Amount	Total
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Please provide the reason for delay in submitting the documents
(Post 30 days from Date of Discharge)

DETAILS OF PRIMARY INSURED BANK ACCOUNT: (SECTION G)

PAN: ☐☐☐☐☐☐☐☐☐☐

Account No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Name and Branch: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Cheque/DD Payable details: _____ IFSC Code: | | | | | | | | | | | | | |

Please provide a Cancelled cheque of Proposer (with printed payee Name)

DECLARATION BY THE INSURED (SECTION H)

I hereby declare that the information furnished in this Claim Form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. **I also consent & authorize TPA/insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made.** I hereby declare that I have included all the bills/ receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: | | | | | | | | Signature of the Insured _____

Place _____

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(PART-B)

To be filled in by the Hospital. The issue of this Form is not to be taken as an admission of liability. Please include the original preauthorization request form in lieu of PART A

Please fill-up this form in CAPITAL LETTERS

DETAILS OF HOSPITAL (SECTION A)

Name of the Hospital:

ROHINI ID:

Type of Hospital: ☐ Network ☐ Non Network (If non network fill section D)

Facilities available in the hospital: OT: ☐☐ ICU: ☐☐

Name of the treating Doctor: Prefix ☐☐☐ First Name Middle Name Last Name

Qualification: Phone No.:

Registration No.: (with State Code)

DETAILS OF THE PATIENT ADMITTED (SECTION B)

Name of the Patient: Prefix ☐☐☐ First Name Middle Name Last Name

IP Registration Number: Gender: ☐ M ☐ F Age: ☐☐ Years ☐☐ Months ☐☐

Date of Birth: Date of Admission: Time:

Date of Discharge: Time:

Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

If Maternity: i) Date of Delivery: i) Gravida Status: ☐ G ☐ P ☐ A ☐ L

Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

Total claimed amount ₹:

DETAILS OF AILMENT DIAGNOSED (PRIMARY) (SECTION C)

ICD 10 Codes:	Description	ICD 10 PCS:	Description
i) Primary Diagnosis		i) Procedure 1	
ii) Additional Diagnosis		ii) Procedure 2	
iii) Co-morbidities		iii) Procedure 3	
iv) Co-morbidities		iv) Details of Procedure	

Pre-authorization obtained: ☐ Yes ☐ No Pre-authorization Number:

If authorization by network hospital not obtained, give reason:

Hospitalization due to injury: ☐ Yes ☐ No

i) If yes, give cause: ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption

ii) If injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach report)

iii) If Medico legal: ☐ Yes ☐ No iv) Reported to Police: ☐ Yes ☐ No v) FIR No.:

vi) If not reported to police give reason:

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ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (SECTION D)
(ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

Name of the Hospital:

Address:

City/Town District

Pin Code State

E-Mail Phone

Registration No: with State Code Hospital PAN: Number of Inpatient beds:

Facilities available in the hospital: i) OT: ☐ Yes ☐ No ii) ICU: ☐ Yes ☐ No iii) Others _____

DECLARATION BY THE HOSPITAL (SECTION E)
(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place _____ Signature and Seal of the Hospital Authority _____

Communication details of TPA (kindly submit the dully signed filled claim form along with original documents at following address)

TAGIC Health Claims,TATA AIG General Insurance Company Limited, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900Toll Free: 1800 266 7780 or 1800 229 966 (For Senior Citizens)Website: www.tataaig.com; Email: healthclaimsupport@tataaig.com

Prohibition of Rebates - Section 41 of Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

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Part C - Know Your Customer (KYC)

**With reference to IRDAI Circular No. IRDAI/SDD/MISC/CIR/135/07/2016,
KYC details are required for Individual/ Retail policy holders, if the total claimed amount exceeds ₹100,000**

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

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Tick '✓' wherever applicable.
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) For particular section update, please tick (✓) in the box section number and strike off the sections not required to be updated.
G) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
H) List of two character ISO 3166 country codes is available at the end.
I) KYC number of applicant is mandatory for update application.
J) The 'OTP based E-KYC' check box is to be checked for accounts opened using OTP based E-KYC in non-face to face mode

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update

KYC Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Mandatory for KYC update request)

Account Type* ☐ Normal ☐ Minor ☐ Aadhaar OTP based E-KYC (in non-face to face mode)

☐ 1. PERSONAL DETAILS* (Please refer instruction A at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name				
Father / Spouse Name				
Mother Name				

Date of Birth* ☐☐☐☐☐☐☐☐ Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender

Pan* ☐☐☐☐☐☐☐☐☐☐ ☐ Form 60 furnished

☐ 2. PROOF OF IDENTITY AND ADDRESS* (Please refer instruction B at the end)

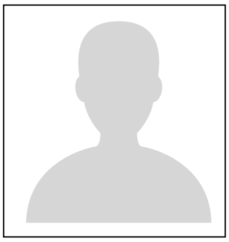
I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

☐ A- Passport Number
☐ B- Voter ID Card
☐ C- Driving Licence
☐ D- NREGA Job Card
☐ E- National Population Register Letter
☐ F- Proof of Possession of Aadhaar

II. ☐ E-KYC Authentication

III. ☐ Offline verification of Aadhaar

☐ PHOTO*



Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

3. CURRENT ADDRESS DETAILS (Please refer instruction B at the end)

☐ Same as above mentioned address (In such cases address detail as below need not be provided)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

- ☐ A- Passport Number
- ☐ B- Voter ID Card
- ☐ C- Driving Licence
- ☐ D- NREGA Job Card
- ☐ E- National Population Register Letter
- ☐ F- Proof of Possession of Aadhaar

II. ☐ E-KYC Authentication

III. ☐ Offline verification of Aadhaar

IV. ☐ Deemed Proof of Address - Document Type code

Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

4. CONTACT DETAILS (All communication will be sent to Mobile number/ Email-ID provided) (Please refer instruction C at the end)

Tel. (Off) - Tel. (Res) -

Email ID Mobile

5. REMARKS (If any)

6. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date: Place:

7. ATTESTATION / FOR OFFICE USE ONLY

Documents Received

- ☐ Certified Copies
- ☐ E-KYC data received from UIDAI
- ☐ Data received from offline verification
- ☐ Digital KYC Process
- ☐ Equivalent e-document
- ☐ Video Based KYC

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KYC VERIFICATION CARRIED OUT BY		INSTITUTION DETAILS	
Date		Name	
Emp. Name		Code	
Emp. Code			
Emp. Designation			
Emp. Branch			
[Employee Signature]		[Institution Stamp]	

CENTRAL KYC REGISTRY | Instructions / Checklist / Guidelines for filling Individual KYC Application Form

A Clarification / Guidelines on filling 'Personal Details' section

1 Name: The name should match the name as mentioned in the proof of Identity submitted, failing which the application is liable to be rejected.

2 One of the following is mandatory: Mother's name, Spouse's name, Father's name.

B Clarification / Guidelines on filling 'Current Address details' section

1 Incase of deemed PoA such as utility bill, the document need not be uploaded CKYCR

2 PoA to be submitted only if the submitted PoI does not have current address or address as per PoI is invalid or not in force.

3 State/ U.T Code and Pin/Post code will not be mandatory for Overseas addresses.

4 In Section 2, one of I, II, and III is to be selected. In case of online E-KYC authentication, II is to be selected.

5 In Section 3, one of I, II, III and IV is to be selected. In case of online E-KYC authentication, II is to be selected.

6 List of documents for 'Deemed Proof of Address'.

Document Code	Description
01	Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone, piped gas, water bill).
02	Property or Municipal tax receipt
03	Pension or family pension payment order(PPOs) issued to retired employees by Government Departments or Public Sector Undertakings, if they contain the address
04	Letter of allotment of accommodation from employer issued by State Government or Central Government Departments, statutory or regulatory bodies, public sector undertakings, scheduled commercial banks, financial institutions and listed companies and leave and licence agreements with such employers alloying official accommodation.

7 Regulated Entity (RE) shall redact(first 8 digits) of the Aadhaar number from Aadhaar related data and documents such as proof of possession of Aadhaar, while uploading on CKYCR.

8 "Equivalent e-document" means an electronic equivalent of a document, issued by the issuing authority of such a document with its valid digital signature including Intermediaries Providing Digital Locker Facilities) Rules, 2016.

9 'Digital KYC process' has to be carried out as stipulated in the PML Rules, 2005.

C Clarification/ Guidelines on filling 'Contact details' section

1 Please mention two-digits country code and 10 digit mobile number (e.g. for Indian mobile number mention 91-9999999999).

2 Do not add '0' at the beginning of the Mobile number.

D Clarification/ Guidelines on filling 'Related Person details' section

1 Provide the KYC number of a related person, if available.

E Clarification on Minor

1 Guardian details are optional for minors above 10 years of age for opening of bank account only

2 However, in case guardian details are available for minors above 10 years of age, the same (or CKYCR number of guardian) is to be uploaded.

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List of two – digit state / U.T codes as per Indian Motor Vehicle Act, 1988

State / U.T	Code
Andaman & Nicobar	AN
Andhra Pradesh	AP
Arunachal Pradesh	AR
Assam	AS
Bihar	BR
Chandigarh	CH
Chattisgarh	CG
Dadra and Nagar Haveli	DN
Daman & Diu	DD
Delhi	DL
Goa	GA
Gujarat	GJ
Haryana	HR

State / U.T	Code
Himachal Pradesh	HP
Jammu & Kashmir	JK
Jharkhand	JH
Karnataka	KA
Kerala	KL
Lakshadweep	LD
Madhya Pradesh	MP
Maharashtra	MH
Manipur	MN
Meghalaya	ML
Mizoram	MZ
Nagaland	NL
Orissa	OR

State / U.T	Code
Pondicherry	PY
Punjab	PB
Rajasthan	RJ
Sikkim	SK
Tamil Nadu	TN
Telangana	TS
Tripura	TR
Uttar Pradesh	UP
Uttarakhand	UA
West Bengal	WB
Other	XX

List of ISO 3166 two- digit Country Code

Country	Country Code	Country	Country Code	Country	Country Code	Country	Country Code
Afghanistan	AF	Dominican Republic	DO	Libya	LY	Saint Pierre and Miquelon	PM
Aland Islands	AX	Ecuador	EC	Liechtenstein	LI	Saint Vincent and the Grenadines	VC
Albania	AL	Egypt	EG	Lithuania	LT	Samoa	WS
Algeria	DZ	El Salvador	SV	Luxembourg	LU	San Marino	SM
American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Andorra	AD	Eritrea	ER	Macedonia, the former Yugoslav Republic of	MK	Saudi Arabia	SA
Angola	AO	Estonia	EE	Madagascar	MG	Senegal	SN
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctica	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antigua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL
Argentina	AR	Fiji	FJ	Mali	ML	Singapore	SG
Armenia	AM	Finland	FI	Malta	MT	Sint Maarten (Dutch part)	SX
Aruba	AW	France	FR	Marshall Islands	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martinique	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Islands	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritus	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Mayotte	YT	South Africa	ZA
Bahrain	BH	Gambia	GM	Mexico	MX	South Georgia and the South Sandwich Islands	GS
Bangladesh	BD	Georgia	GE	Micronesia, Federated States of	FM	South Sudan	SS
Barbados	BB	Germany	DE	Moldova, Republic of	MD	Spain	ES
Belarus	BY	Ghana	GH	Monaco	MC	Sri Lanka	LK

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Belgium	BE	Gibraltar	GI	Mongolia	MN	Sudan	SD
Belize	BZ	Greece	GR	Montenegro	ME	Suriname	SR
Benin	BJ	Greenland	GL	Montserrat	MS	Svalbard and Jan Mayen	SJ
Bermuda	BM	Grenada	GD	Morocco	MA	Swaziland	SZ
Bhutan	BT	Guadeloupe	GP	Mozambique	MZ	Sweden	SE
Bolivia, Plurinat onal State of	BO	Guam	GU	Myanmar	MM	Switzerland	CH
Bonaire, Sint Eustatius and Saba	BQ	Guatemala	GT	Namibia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	NR	Taiwan, Province of China	TW
Botswana	BW	Guinea	GN	Nepal	NP	Tajikistan	TJ
Bouvet Island	BV	Guinea-Bissau	GW	Netherlands	NL	Tanzania, United Republic of	TZ
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
Britsh I ndian Ocean Territory	IO	Haiti	HT	New Zealand	NZ	Timor-Leste	TL
Brunei Darussalam	BN	Heard Island and McDonald Islands	HM	Nicaragua	NI	Togo	TG
Bulgaria	BG	Holy See (Vatcan City State)	VA	Niger	NE	Tokelau	TK
Burkina Faso	BF	Honduras	HN	Nigeria	NG	Tonga	TO
Burundi	BI	Hong Kong	HK	Niue	NU	Trinidad and Tobago	TT
Cabo Verde	CV	Hungary	HU	Norfolk Island	NF	Tunisia	TN
Cambodia	KH	Iceland	IS	Northern Mariana Islands	MP	Turkey	TR
Cameroon	CM	India	IN	Norway	NO	Turkmenistan	TM
Canada	CA	Indonesia	ID	Oman	OM	Turks and Caicos Islands	TC
Cayman Islands	KY	Iran, Islamic Republic of	IR	Pakistan	PK	Tuvalu	TV
Central African Republic	CF	Iraq	IQ	Palau	PW	Uganda	UG
Chad	TD	Ireland	IE	Palestine, State of	PS	Ukraine	UA
Chile	CL	Isle of Man	IM	Panama	PA	United Arab Emirates	AE
China	CN	Israel	IL	Papua New Guinea	PG	United Kingdom	GB
Christmas Island	CX	Italy	IT	Paraguay	PY	United States	US
Cocos (Keeling) Islands	CC	Jamaica	JM	Peru	PE	United States Minor Outlying Islands	UM
Colombia	CO	Japan	JP	Philippines	PH	Uruguay	UY
Comoros	KM	Jersey	JE	Pitcairn	PN	Uzbekistan	UZ
Congo	CG	Jordan	JO	Poland	PL	Vanuatu	VU
Congo, the Democratc Republic of the	CD	Kazakhstan	KZ	Portugal	PT	Venezuela, Bolivarian Republic of	VE
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribati	KI	Qatar	QA	Virgin Islands, British	VG
Cote d'Ivoire !Côte d'Ivoire	CI	Korea, Democratic People's Republic of	KP	Reunion !Réunion	RE	Virgin Islands, U.S.	VI
Croata	HR	Korea, Republic of	KR	Romania	RO	Wallis and Futuna	WF
Cuba	CU	Kuwait	KW	Russian Federaton	RU	Western Sahara	EH
Curacao !Curaçao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE

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MediCare Premier New UIN: TATHLIP23167V032223 • **MediCare Old UIN:** TATHLIP21224V022021 • **MediCare New UIN:** TATHLIP23118V032223
MediCareProtect UIN: TATHLIP21225V022021 • **Medicare Plus UIN:** TATHLIP21253V022021

Cyprus	CY	Lao People's Democratic Republic	LA	Saint Barthelemy !Saint Barthélemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kits and Nevis	KN		
Djibout	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martin (French part)	MF		

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