CLAIMS SETTLEMENT PROCEDURES AND TIMEFRAMES

SOFTLOGIC LIFE INSURANCE PLC

Document Details

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1.0	01.10.2026	This consolidated document integrates the claimant-facing claims procedure journey, required claim documentation, and claim service standards into a single controlled procedural document, in accordance with the regulatory requirements.	Life Operations

Table of Contents

1. Introduction

This Claims Settlement Procedures and Timeframes document sets out the claims journey for Individual Life and Group Life policies issued by Softlogic Life Insurance PLC. It provides a clear and consistent written reference for how a claim is submitted, registered and assessed, referred for investigation where necessary, and then settled or the decision communicated to you. It is issued in line with the requirements of the Insurance Regulatory Commission of Sri Lanka (IRCSL).

A claim is settled without difficulty where the documentation is complete at the point of submission. Most delay arises from documents that are missing, unclear, or sent to the wrong place. This document is published so that you can establish, before a claim arises, exactly what will be required of you – and so that our branches, Care Centre and customer service teams work from the same information you hold.

This document sets out the claims process only. Your claim is assessed based on the terms, conditions and benefit limits in your policy document and benefit schedule, which confirm the cover that applies to you.

2. Scope and Objectives

This document covers claims arising under Individual Life and Group Life policies, including health claims under Individual Life, the Good Health Series, and Group Life, as well as death, critical illness, and disability claims.

2.1 Scope

This document applies to all policyholders, Life Assured persons, members and claimants of Softlogic Life Insurance PLC. It covers the full claim journey, from the moment a claim is intimated to the Company through to the settlement or rejection of the claim.

The following claim types are within scope:

Claim type	Policies covered
Individual Life – Health	Individual Life policies with health benefits/riders attached.
Good Health Series	Good Health Series global health insurance policies, offered in partnership with AXA Global Healthcare.
Group Life – Corporate Health	Group Life policies where hospitalisation and out-patient cover is included in the policy schedule.
Individual and Group Life – Death	Individual, Group Life and Decreasing Term Assurance (DTA) policies, and the Group Life Assurance Policy for Dialog Customers.
Individual and Group Life – Critical Illness	Individual and Group Life policies.
Individual and Group Life – Disability	Individual, Group Life and Decreasing Term Assurance (DTA) policies.

2.2 Objectives

The objectives of this document are:

- to set out, in one place, the end-to-end claims journey and the procedure that applies to each type of claim;
- to state clearly the documents required for each claim type and benefit, so that claims are not delayed by avoidable gaps in documentation;
- to publish the timeframes within which the Company acknowledges a claim, notifies requirements, takes a decision, and settles or rejects a claim;
- to identify the situations in which a claim requires pre-authorisation, prior notification, additional information or referral for investigation;
- to explain how a claim is assessed, how claim payments are made, and what happens where documents remain outstanding;
- to set out the contact points for intimating a claim, submitting documents and checking the status of a claim; and
- to provide a single, consistent reference for policyholders, claimants, branches, the Care Centre and customer service teams.

3. Definitions and Abbreviations

The following terms and abbreviations are used in this document.

Term	Meaning used in this procedure
AOHP	Family Healthcare Super Benefit + Overseas Treatment Benefit I
AXA	AXA Global Healthcare – the Company's international claims handler under the Softlogic Life Good Health Series plan
BSA	Basic Sum Assured
Cashless claim	A claim where Softlogic Life settles the eligible hospital costs directly with an empaneled hospital, so that you are not required to pay for covered treatment at the point of discharge
CEFT	Common Electronic Fund Transfer Switch
CIC	Critical Illness Claim
DTA / DTAP	Decreasing Term Assurance / Decreasing Term Assurance Policy
EPHR	Escalating Premier Health Benefit
Euro Centre	The Company's overseas assistance centre for Individual Life health claims arising outside Sri Lanka
FHC	Family Healthcare Benefit
FIB	Family Income Benefit
FNAC	Fine Needle Aspiration Cytology

Term	Meaning used in this procedure
GOP	Guarantee of Payment issued to a hospital or treating facility for approved eligible costs, under cashless claims
GPHR / GPHP	Premier Health Rider Benefit
HB	Hospitalization Per Day Benefit
HCM panel	Health Claims Management panel
IRCSL	Insurance Regulatory Commission of Sri Lanka
JMO	Judicial Medical Officer
Life Assured	The person whose life is insured under the policy
NPW	Non-Paying Ward
OPD	Out-Patient Department
OTP	One-Time Password
PPD	Partial Permanent Disability
Reimbursement claim	A claim where you have already paid eligible expenses and submit the relevant documents so that the Company can reimburse you
SFHC	Family Healthcare Super Benefit
SLIP	Sri Lanka Interbank Payment System
SOHP	Family Healthcare Super Benefit + Overseas Treatment Benefit II
TPD	Total Permanent Disability
WOP	Waiver of Premium

4. Claims Settlement Journey

Every claim follows steps, in whatever your policy or benefit type is.

	Steps	Description
1	**Select your policy type**	Individual Life or Group Life
2	**Select your claim type**	Individual Life – Health Good Health Series Group Life – Corporate Health Individual and Group Life – Death Individual and Group Life – Critical Illness Individual and Group Life – Disability
3	**Submit your claim**	Submit the required documents for your claim type at Head Office or at any branch. For cashless hospitalization and for treatment outside Sri Lanka, notify us before admission wherever possible. Contact us on 1312 for more details.
4	**Assessment and settlement**	Upon receipt of your claim documents, we assess your claim and either settle it, request further information, refer it for investigation, or notify you of a rejection together with the reasons.

5. Claims Handling Procedure

This section sets out the procedure and the documents required for each claim type. Identify your policy type and your claim type, then go to the sub-section that applies.

5.1 Step 1 – Select your policy type

Policy type	Who this applies to
Individual Life	This applies to policyholders who hold an individual policy in their own name, including: • Life insurance policies with life, critical illness, disability, or health benefits attached; • Decreasing Term Assurance policies issued in connection with a loan facility.
Group Life	This applies to individuals covered under a Group Life policy arranged by an employer, association, society, etc.

5.2 Step 2 – Select your claim type

Claim type	Section Reference
Individual Life – Health	Section 5.3
Good Health Series	Section 5.4
Group Life – Corporate Health	Section 5.5
Individual and Group Life – Death	Section 5.6
Individual and Group Life – Critical Illness	Section 5.7
Individual and Group Life – Disability	Section 5.8

5.3 Individual Life – Health

This sub-section applies to Individual Life policyholders with health benefits attached to their policy. A claim may be settled on a cashless basis at an empanelled hospital, or on a reimbursement basis where you have already paid.

5.3.1 Health benefits and riders

Depending on your policy, one or more of the following benefits may be attached. Your benefit schedule confirms which apply to you and the limits that apply.

- Hospitalization Per Day Benefit (HB)
- Family Healthcare Benefit (FHC)
- Family Healthcare Super Benefit (SFHC)
- Family Healthcare Super Benefit + Overseas Treatment Benefit I (AOHP)
- Family Healthcare Super Benefit + Overseas Treatment Benefit II (SOHP)
- Premier Health Rider Benefit (GPHR and GPHP)
- Escalating Premier Health Benefit (EPHR)
- Universal Health Shield Benefit

5.3.2 Cashless hospitalisation

Cashless hospitalisation allows you to receive treatment at a Softlogic Life empaneled hospital without paying up front for eligible expenses. The Company settles the hospital bill directly, subject to the terms, conditions and benefit limits of your policy. The facility is available to both Individual Life and Group Life policyholders, and is coordinated by a Cashless Operations Team that functions 24 hours a day, 7 days a week.

Admission

	What happens
1	Contact the 1312 hotline before or on admission and provide your Membership Number, Policy Number or NIC Number. Pre-authorisation and timely notification to 1312 are mandatory to initiate the cashless facility.
2	The admission details are recorded and a Claim Number is generated. An SMS confirmation with the Claim Number is sent to you, confirming that the admission has been recorded.
3	Present the reference number together with your insurance or membership card at the hospital.
4	The hospital provides a Softlogic Life claim form. Complete it and return it to the hospital.
5	You receive the required medical treatment.

Discharge and settlement

	What happens
1	The hospital forwards the final bills, diagnosis card and detailed bill breakdowns to Softlogic Life.
2	The claim is assessed against your policy terms. The Company will approve and proceed with payment, request additional information, or reject the claim in accordance with the applicable policy terms.
3	For approved claims the Company issues the Guarantee of Payment (GOP) to the hospital, stating the reference number, bill amount and claim liability.
5	Any amounts not covered under the policy are settled directly by you with the hospital.
6	Once all payments have been settled you are discharged from the hospital.

Requirement type	Documents required
Cashless claims	• Insurance card or membership card, produced at admission • Claim Number obtained from the Care Centre on 1312 • Copy or digital format of the original Diagnosis Card issued by the treating doctor or hospital • Hospital invoice – digital format of the original invoice covering all medical charges • Claim form – duly completed and signed, and certified by the hospital authority • Final detailed bill with breakdowns, at discharge • All relevant clinical documents

5.3.3 Reimbursement claims

Where you have already paid for eligible treatment, submit the documents listed below. A copy of the Life Assured's bank book or bank statement is required for every benefit, as payment is made to that account.

Requirement type	Documents required
HB claim	• Copy or digital format of the original Diagnosis Card • Claim form – not required if the Diagnosis Card is duly written
Indoor claims	• Claim form – not required if the Diagnosis Card is duly written • Copy or digital format of the original Diagnosis Card • Coloured image of the original final hospital bill • Coloured image of the original final hospital paid receipt

Sub-benefits

Requirement type	Documents required
Pharmacy bills	• Copy or digital format of the original prescription • Coloured copy or digital format of the original pharmacy bill
Pre & post hospitalization benefit	• Coloured copy or digital format of the original bill
Optical benefit	• Copy or digital format of the original prescription • Coloured copy or digital format of the original optical bill
Dental benefit	• Copy or digital format of the original prescription – this may be waived off if the bill details the prescription • Coloured copy or digital format of the original bill
Wellbeing cover	• Coloured copy or digital format of the original bill
0.5% Nonpaying ward benefit – NPW (GPHR and SOHP benefit)	• Copy or digital format of the original Diagnosis Card • Claim form – not required if the Diagnosis Card is duly written • For NPW expenses – coloured copy or digital format of the original bill

- At the discretion of the Company, additional documentation may be requested – for example a break-up bill, a JMO report or a police report.
- If a verified bank account is available; unless otherwise the customer requests for a cheque all above claim payments will be transferred via CEFT/SLIP.
- If an account has been verified and maintained for the past 24 months, and the client requests claim payment remittance to the same account, additional verification is not required.

5.3.4 Overseas Hospitalization

Individual Life health claims arising outside Sri Lanka are handled with the assistance of Euro Centre, the Company's overseas assistance centre. Whether the ospitalization is planned or an emergency, intimate the claim to Euro Centre on +66 2569 0094. Admission must be at an approved hospital. You settle the hospital bill directly and submit the claim documents to the Company for reimbursement.

Planned Hospitalization

	What happens
1	Submit a pre-authorisation request to the Company before admission.
2	The Company reviews the request and, if it is approved, issues the pre-authorisation for the planned ospitalization and informs Euro Centre.
3	Intimate the claim to Euro Centre on +66 2569 0094.
4	Euro Centre notifies the Company of the claim, and the Company confirms your policy details to Euro Centre.
5	You are admitted at an approved hospital, receive the required medical treatment, and settle the hospital bill directly with the hospital.
6	Share all relevant claim documents with the Company within 5 working days of discharge.
7	The claim is assessed against your policy terms, and the decision is communicated to you as set out below.

Unplanned or emergency hospitalisation

	What happens
1	Pre-authorisation is not required, but the hospitalisation must be notified within 48 hours by intimating the claim to Euro Centre on +66 2569 0094.
2	Euro Centre notifies the Company of the claim, and the Company confirms your policy details to Euro Centre.
3	You receive the required medical treatment at an approved hospital and settle the hospital bill directly with the hospital.
4	Share all relevant claim documents with the Company within 5 working days of discharge.
5	The claim is assessed against your policy terms, and the decision is communicated to you as set out below.

Requirement type	Documents required
Overseas hospitalisation claims	• Copy or digital format of the original Pre-Authorisation form, for a planned hospitalisation • Copy or digital format of the original Diagnosis Card • Coloured image of the original final hospital bill • Coloured image of the original final hospital cash receipt • Copy of the Life Assured's bank book or bank statement

The time taken to collect the documents may vary depending on the gravity of the case and the availability of documents with Euro Centre.

Outcome	What happens next
Approved	Payment is processed in favour of the Life Assured in Sri Lankan Rupees.
Pending – further information required	A request for the pending requirements is sent to you by official letter. The settlement timeframe recommences once the last outstanding document is received.
Rejected or repudiated	The decision is communicated to you by official letter, together with the reasons for it.

5.4 Good Health Series

The Good Health Series is a global health insurance cover offered by Softlogic Life in partnership with AXA Global Healthcare. Cashless treatment in Sri Lanka is managed by the Softlogic Life Care Centre. Treatment outside Sri Lanka is handled by AXA Global Healthcare.

In an emergency, make sure that you, a member of the hospital staff, a family member or a work colleague contacts the Company within 2 days of admission. Assistance is available 24 hours a day, 365 days a year for medical emergencies, including evacuation and transportation.

Inside Sri Lanka	Softlogic Life Care Centre	1312	info@softlogiclife.lk
Outside Sri Lanka	AXA Global Healthcare	+44 189 277 2575	partners.health@axa.com

5.4.1 Cashless hospitalisation - Inside Sri Lanka

	What happens
1	Admission notification – contact the Care Centre on 1312 on or before admission.
2	Eligibility verification – the Care Centre verifies your eligibility and policy cover.
3	Admission processing – the admission is processed and recorded in the system.
4	Discharge confirmation – discharge is confirmed with the Care Centre.
5	Discharge documentation – the hospital collects all discharge documents.
6	Documents uploading – the documents are uploaded into the claims system.
7	Claim register updated and payment voucher generated.
8	Voucher approved and payment processed.

Where an admission exceeds 3 days, the following are provided prior to discharge.

Requirement type	Documents required
Prior to discharge – admission exceeding 3 days	• Pre-assessment form • Complete admission notes at the time of hospitalisation • Latest interim bill • Daily treatment plan • All diagnostic reports obtained during the admission • Past medical treatment records, where applicable • Expected discharge date

5.4.2 Cashless hospitalisation - Outside Sri Lanka

For admissions outside Sri Lanka, the cashless claim is handled by AXA Global Healthcare, which issues a Guarantee of Payment directly to the treating facility.

Situation	Procedure
Planned admission	Complete the pre-admission form and submit it to the AXA Partners Team before admission. AXA obtains cost and clinical information from the hospital. If the admission is authorised, AXA issues a Guarantee of Payment to the treating facility for eligible costs.
Emergency admission	You or your representative contacts the AXA Partners Team immediately and provides the emergency, hospital and other pertinent details. AXA obtains the clinical information and costs, issues a Guarantee of Payment for eligible costs to the treating facility, and settles eligible costs directly.

Situation	Procedure
Medical evacuation	Contact the AXA Partners Team immediately, providing all pertinent details. The International Assistance Provider mobilises local resources and works with the treating doctor and facility to determine whether evacuation is required and to which facility. A Guarantee of Payment for eligible costs is issued once the situation has been assessed.
Admission declined	AXA informs the relevant parties of the decision and the reasons for the declination.

5.4.3 Reimbursement claims

Document	Hard copies	Soft copies
Duly completed Indoor claim form with member's details	**Required**	**Required**
Original hospital bill or bills	**Required**	**Required**
Original paid receipts	**Required**	**Required**
Original Diagnosis Card	**Optional**	**Required**
Clear copy of the Diagnosis Card	**Required**	**Optional**
Copy of the Life Assured's bank book or bank statement	**Required**	**Required**

- The above mentioned document requirements apply to indoor claims and to OPD claims. For OPD claims the original prescription bearing the doctor's seal is required in place of the hospital bill where no hospital bill exists.
- Where you have paid for overseas treatment yourself, your claim, together with all invoices, must be submitted within 90 days of the date of service or treatment; claims submitted later will not be considered for reimbursement.

5.5 Group Life – Corporate Health

Group Life health cover applies where such cover is included and appears in the Group Life policy schedule. Where, during the policy period, the member is hospitalised due to bodily injury or sickness necessitating medical, surgical or out-patient treatment, the Company indemnifies the member for the expenses up to the limits listed in the policy schedule.

5.5.1 Cashless claims

Cashless hospitalisation is available to Group Life members at Softlogic Life empanelled hospitals. The admission, discharge and settlement steps follow the process set out below with the required documents required are as follows.

Admission

	What happens
1	Contact the 1312 hotline before or on admission and provide your Membership Number, Policy Number or NIC Number. Pre-authorisation and timely notification to 1312 are mandatory to initiate the cashless facility.
2	The admission details are recorded and a Claim Number is generated. An SMS confirmation with the Claim Number is sent to you, confirming that the admission has been recorded.
3	Present the reference number together with your insurance or membership card at the hospital.
4	The hospital provides a Softlogic Life claim form. Complete it and return it to the hospital.
5	You receive the required medical treatment.

Discharge and settlement

	What happens
1	The hospital forwards the final bills, diagnosis card and detailed bill breakdowns to Softlogic Life.
2	The claim is assessed against your policy terms. The Company will approve and proceed with payment, request additional information, or reject the claim in accordance with the applicable policy terms.
3	For approved claims the Company issues the Guarantee of Payment (GOP) to the hospital, stating the reference number, bill amount and claim liability.
5	Any amounts not covered under the policy are settled directly by you with the hospital.
6	Once all payments have been settled you are discharged from the hospital.

Requirement type	Documents required
Cashless claims	• Insurance card or membership card, produced at admission • Claim Number obtained from the Care Centre on 1312 • Copy or digital format of the original Diagnosis Card issued by the treating doctor or hospital • Hospital invoice – digital format of the original invoice covering all medical charges • Claim form – duly completed and signed, and certified by the hospital authority • Final detailed bill with breakdowns, at discharge • All relevant clinical documents

5.5.2 Reimbursement claims

Requirement type	Documents required
Indoor claims	• Original Diagnosis Ticket • Original hospital bill • Original cash receipts • Claim form • Other supporting documents
OPD claims – drugs, investigations and consultations	• Original prescription • Original cash receipts • Consultation receipt
Spectacles bills	• Original prescription • Original cash receipts • Consultation receipt
Dental bills	• Original prescription • Original cash receipts • Consultation receipt

Points to note on Group Life claims

- At the discretion of the Company, additional documentation may be requested – for example a break-up bill or an incident report.
- Where documents are submitted digitally, colour images or photographs are mandatory.
- Bank account details are collected separately for all Group Life claims. Where a verified bank account is available, claim payments are transferred via CEFT or SLIP unless the Life Assured requests a cheque.

Digital Submission portal - InstaClaim - www.instaclaim.lk

- This is an online corporate claims portal for members. You can Log in using your registered mobile number and the One-Time Password (OTP) sent to it. Staff mobile numbers must be registered with Softlogic Life Insurance PLC before the first login. Where bank account details are uploaded through the InstaClaim portal, the same details are retained for future claim payment remittance.

5.6 Death Claims

This section applies to death claims under Individual, Group Life, Decreasing Term Assurance (DTA), Group Life Assurance Policy for Dialog Customers. For Group Life schemes, the company HR or authorised officer notifies Softlogic Life of the death of the member together with the supporting documents.

5.6.1 When a death claim arises

A death claim arises where the death of the Life Assured, or of the Spouse where covered, occurs prior to the expiry or maturity of an active policy.

Nature of death	Meaning
Natural death	Death due to a non-accidental cause, such as illness, old age or a medical condition.
Accidental death	Death caused solely and directly by external, violent, and visible means (covered separately if rider exists).
Suicide	Death within one year of policy commencement/revival due to suicide is not covered (as per policy wording)
Missing person	Where the Life assured has had not been heard of for a period of one year by those who would have naturally heard of, if had been alive. In such an event benefit shall become due after a period of seven years computed from the time when Life Assured has ceased to be heard of.
Free Life Cover	In certain products in Softlogic Life we have provided with "Free Life Cover". And if a death claim may arise within 10 years from the date of maturity or before the Life assured reaching the age of 70 years (Condition may vary as specified in the policy schedule) whichever is earlier, provided premiums have been paid in full and up to the last due date.

5.6.2 Documents required

Requirement type	Documents required
Natural death	• Copy or digital format of the Death Certificate • Duly completed Claimant's Statement • NIC, Birth Certificate or equivalent documentation of the nominee • Valid age proof of the deceased, if not available at commencement • Certified copy of Marriage Certificate in case of Spouse Life (if not available at inception)

Requirement type	Documents required
Accidental death – all natural death requirements plus	• Copy or digital format of the Police Report or JMO Report, where applicable • Copy or digital format of the Court Proceedings with the final court verdict, where applicable
Suicide	• All natural death requirements apply
Missing person – all natural death requirements plus	• Presumption of Death Certificate
Free Life Cover	• Copy or digital format of the Death Certificate • Duly completed Claimant's Statement • NIC/ Birth Certificate or equivalent documentation of the nominee • Valid age proof of the deceased, if not available at commencement
Funeral Expenses Benefit	• Proof of death: either a Certificate of Death or a death notice issued by the hospital • In case of funeral expense benefit request for a family member (if Applicable), the relationship with the member must be confirmed through the following evidence. • Parents - Birth Certificate of Member • Siblings - Birth Certificate of Member and Birth certificate of deceased • Parents in law - Marriage certificate of Member, Birth certificate of Spouse (optional)
Any other requirements – where necessary for sound decision-making	• Last Medical Attendance Certificate completed by the last treated doctor • Copy or digital format of the Coroner's Inquest Proceedings • Copy or digital format of the Postmortem Report • Treatment records, investigations and clinic book records • Any other document or evidence required for claim settlement

5.6.3 Who the benefit is paid to

- The benefit is paid to the nominee, the legal heirs, or the assignee.
- Where the nominee is a minor, payment is deposited to the minor's account.
- Where there is no nomination, disbursement is subject to a testimonial or the Grama Sevaka's confirmation.
- Under Group Life policies, payment is made to the members's nominated person (nominee). If not nominated will be paid to the employer the corporate or the society (affinity scheme).
- Under Decreasing Term Assurance policies, payment is made to the relevant financial institution.

5.6.4 Important conditions

- For Individual claims, the claim is disbursed to the nominee on receipt of the Discharge Form.
- Where the nominee is accused of, suspected of, or found guilty in relation to the death of the Life Assured, payment is withheld until the court's decision is reached.
- Where a policy has acquired a surrender value and has not lapsed for more than 6 months, admissibility is subject to recovery of the due premium payments.
- Where a policy has acquired a surrender value and has lapsed for more than 6 months, admissibility is subject to the acquired paid-up value with bonus.
- Where a policy has not acquired a surrender value, no liability is admissible.
- Under a Decreasing Term Assurance policy, the sum assured payable is the lesser of the amount specified in the Primary Benefit Schedule corresponding to the month of death, or the capital outstanding loan balance recorded by the lending institution as at the date of death, excluding overdue or defaulted payments and interest components.

5.6.5 Benefits payable in addition to the Basic Sum Assured

Where the following riders or benefits have been obtained, they are payable in addition to the Basic Sum Assured. Your benefit schedule confirms which apply to your policy.

- Additional Life Benefit (ALB)
- Accidental Death Benefit (ADB)
- Funeral Expenses Benefit (FEB)
- Family Income Benefit on Death (FIB on Death) – a monthly payout upon the death of the main Life Assured
- Super Critical Illness Plus Benefit
- Annual Escalation Benefit
- Child Annuity – where the main Life Assured dies after commencement of child benefits, guaranteed sums falling due for payment are doubled
- Waiver of Premium (WOP) on Death
- Acquired bonus, for endowment policies, and minimum guaranteed refund, for the Premium Relief plan

5.7 Critical Illness Claims

This sub-section applies to critical illness claims under Individual and Group Life policies. Where the Life Assured, or the Spouse where applicable, is diagnosed for the first time as suffering from any of the specified illnesses defined under the critical illness benefit schedule, or is proved to have undergone any of the surgeries listed under that benefit, the Company pays the benefit.

Three types of critical illness benefit are granted under the policies at Softlogic Life:

- Critical Illness Benefit
- Critical Illness Super Benefit
- Critical Illness Super Plus Benefit

Requirement type	Documents required
Critical illness claims	• Duly completed Claimant's Statement • Copy or digital format of the original Diagnosis Card • Attending Physician's questionnaire • Supporting medical reports, investigations and clinic book • Fine Needle Aspiration Cytology (FNAC) and histology reports, as applicable to the illness • Copy of the Life Assured's bank book or bank statement

5.7.1 Who the benefit is paid to

- The benefit is paid to the policyholder.
- Where death occurs after the survival period, the benefit is paid to the nominee or the legal heirs.
- Under Group Life policies, payment is made to the employer or the corporate.

5.8 Disability Claims

This sub-section applies to disability claims under Individual/Agency, Group Life and Decreasing Term Assurance policies. The disability benefit provides financial protection to the Life Assured in the event of disability caused by accident or sickness.

Benefit	What it covers
Total Permanent Disability on sickness	Payable where the Life Assured suffers a total and permanent disability caused by sickness which makes them incapable of performing any occupation for the remainder of their life.
Total Permanent Disability on accident	Payable where the Life Assured suffers a total and permanent disability directly resulting from an accident – for example loss of both eyes, both hands or both legs – which makes them incapable of performing any occupation for the remainder of their life.
Total Permanent Disability due to sickness or accident	Provides full coverage by compensating for total and permanent disability arising from either sickness or accident.
Partial Permanent Disability (PPD)	Payable where the Life Assured suffers a permanent but partial loss of physical function – for example loss of one eye, one hand or one leg. The payout is a percentage of the sum assured, depending on the severity of the disability.
Waiver of Premium on disability	Where the Life Assured is declared totally and permanently disabled, all future premiums are waived. The policy continues in force and the other benefits stipulated in the schedule remain payable as originally planned.

Benefit	What it covers
Family Income Benefit on permanent and total disability	Where the Life Assured becomes permanently and totally disabled as a result of an accident or sickness, and the disability continues for a period of not less than six consecutive months, the Company pays a monthly income equivalent to the amount specified in the policy.

Requirement type	Documents required
Disability claims	• Duly completed Claimant's Statement • Supplemental attending physician's statement for disability, completed by the treated doctor • Diagnosis ticket or tickets and treatment records • Previous treatment records, if any • Age proof, if not available at policy acceptance • Copy of the Life Assured's bank book or bank statement

5.8.1 Who the benefit is paid to

- The benefit is paid to the policyholder.
- Under Decreasing Term Assurance policies, payment is made to the relevant financial institution, broker or agent.
- Under Group Life policies, payment is made to the employer or the corporate.

6. Claim Settlement Service Standards and Timeframes

The service standards below are the benchmarks. Acknowledgement of a claim and notification of the requirements run from the date the claim is intimated. The settlement and rejection standards run from the date on which all required documents have been received by the Company.

6.1 Service standards – claim intimation to settlement

Servicing activity	Cashless Claims	Reimbursement Claims	Corporate Claims	Death, CI and Disability Claims
Acknowledgement of claim and notification of requirements	**Within 30 minutes**	**Within 3 to 5 working days**	**Within 3 to 5 working days**	**Within 3 working days**
Settlement of claim (without investigation)				**Within 7 working days**
Notification of repudiation or rejection, with reasons				**Within 7 working days**
Settlement of claim (with investigation)	–	**Within 14 working days**	**Within 14 working days**	**Within 14 working days**

6.2 When the timeframe starts, and when it pauses

- The acknowledgement standard runs from the date you intimate the claim. At that point the Company confirms your cover and tells you which documents are required.
- The settlement and rejection standards commence only once all necessary documents have been submitted to the Company.
- Where a claim requires a document from a third party – for example a police report, a Judicial Medical Officer (JMO) report or court proceedings – the settlement timeframe is calculated from the date that document is received.
- Where the Company requests further information from you, the timeframe recommences from the date the last outstanding document is received.

7. Assessment, Decision and Settlement Outcomes

7.1 Possible outcomes

Once your claim has been submitted, it is registered and assessed against the terms, conditions and benefit limits of your policy. One of the following outcomes will apply.

Outcome	What happens next
Approved	The claim proceeds to settlement. For cashless claims the Guarantee of Payment is issued to the hospital. For reimbursement and other claims the approved amount is paid as set out in Section 7.2.
Pending – further information required	You are notified of the additional documents or information needed to complete the assessment. For Group Life claims the employer or corporate is notified, and for Decreasing Term Assurance claims the relevant financial institution, broker or agent. The settlement timeframe recommences once the last outstanding document is received.
Referred for investigation	Where an investigation is required, the claim is settled within 14 working days, in accordance with the benchmark for reimbursement, corporate and death, critical illness and disability claims with investigation.
Rejected or repudiated	The Company communicates the decision together with clear reasons for it, within 7 working days for death, critical illness and disability claims. You may appeal against the decision or escalate it.
Ex-gratia or appeal	Any ex-gratia consideration, or an appeal against a claim decision, is subject to management decision.
Reinsurance referral	Where the claim amount exceeds the Company's automatic acceptance limit, the claim is referred to the Company's reinsurers before a final decision is taken.

7.2 How claim payments are made

- For every claim paid to you, a copy of the Life Assured's bank book or bank statement is required, as claim payments are made to that account.
- Where a verified bank account is available, claim payments are transferred by CEFT or SLIP, unless you request a cheque. Where no verified bank account is available, a cheque is issued and dispatched to the branch.
- Where an account has been verified and maintained for the past 24 months and you request claim payment to that same account, no additional verification is required.
- For Good Health claims, you may choose to be paid by bank transfer, foreign draft or cheque. Indicate your preferred method on the claim form.
- For Good Health cashless claims in Sri Lanka, payment is made directly to the hospital.
- Approved Individual Life overseas health claim payments are processed in Sri Lankan Rupees.
- For cashless claims, any amount not covered under the policy, including deductions and exclusions identified during claim processing, is settled directly by you with the hospital.

8. Customer Enquiries and Claim Status

All claim intimation, document submission, status enquiries and general claims assistance are handled through the below contact points. This is the single point of reference for contacting Softlogic Life about a claim – you do not need to use more than one contact point. Please quote your policy number, membership number or claim reference number whenever you contact us.

8.1 Contact and submission channels

Contact Point	Details
Care Centre	1312 | 0112 333 888 WhatsApp: 0112 333 888
Email	life.claims@softlogiclife.lk or info@softlogiclife.lk
Softlogic Life branch	Branch locator: softlogiclife.lk/branch-networks
Head Office	Level 16, One Galle Face Tower, Colombo 02, Sri Lanka
InstaClaim – Group Life online portal	www.instaclaim.lk
Euro Centre – Individual Life health treatment outside Sri Lanka	+66 2569 0094
AXA Global Healthcare – Good Health treatment outside Sri Lanka	+44 189 277 2575 partners.health@axa.com
Corporate website	www.softlogiclife.lk

8.2 Obtaining a claim form

Claim forms are available at any Softlogic Life branch, from the Care Centre on 1312, and from the hospital at the time of a cashless admission.

For Good Health policies, one claim form is required for each medical condition within each period of insurance, regardless of how many bills you submit. If you receive further bills for the same condition after submitting your claim form, send them in with a covering note quoting your membership number, or attach a copy of your original claim form.

8.3 Information to have ready when you contact us

To allow us to identify your cover quickly, please have the following ready:

- Your full name and date of birth
- Your policy number, membership number or NIC number
- The name of the hospital and the expected or actual date of admission
- Your claim reference number, if a claim has already been intimated

Annexure A – Claim Type and Document Matrix

This annexure summarises the documents required for each claim type. A copy of the Life Assured's bank book or bank statement is required for every claim that is paid to you; for Group Life claims, bank account details are collected separately. Where documents are submitted digitally, colour images are mandatory. At the discretion of the Company, additional documents may be requested. Full details are set out in the sections referenced.

Claim type	Requirement type	Documents required	Section
Individual Life – Health	Cashless claims	Insurance or membership card; Claim Number from 1312; claim form certified by the hospital; Diagnosis Card; hospital invoice; final detailed bill; clinical documents	**5.3.2**
Individual Life – Health	HB claim	Diagnosis Card; claim form if the Diagnosis Card is not duly written	**5.3.3**
Individual Life – Health	Indoor claims	Claim form if the Diagnosis Card is not duly written; Diagnosis Card; final hospital bill; final hospital paid receipt	**5.3.3**
Individual Life – Health	Pharmacy bills	Copy or digital format of the Original Prescription and pharmacy bill	**5.3.3**
Individual Life – Health	Pre & post hospitalization benefit	Copy or digital format of the Original Bill	**5.3.3**
Individual Life – Health	Optical benefit	Copy or digital format of the Original Prescription and optical bill	**5.3.3**
Individual Life – Health	Dental benefit	Copy or digital format of the Original Prescription, and dental bill	**5.3.3**
Individual Life – Health	Wellbeing cover	Copy or digital format of the Original Bill	**5.3.3**
Individual Life – Health	0.5% Nonpaying ward benefit – NPW (GPHR and SOHP benefit)	Copy or digital format of the Original Diagnosis Card; Claim form if the Diagnosis Card is not duly written; coloured copy or digital format of the original NPW bill	**5.3.3**

Claim type	Requirement type	Documents required	Section
Individual Life – Health	Overseas hospitalisation claims	Pre-Authorisation form for a planned hospitalisation; Diagnosis Card; final hospital bill; final hospital cash receipt. Intimate the claim to Euro Centre, within 48 hours if unplanned; share documents within 5 working days of discharge	**5.3.4**
Good Health Series	Cashless hospitalisation – inside Sri Lanka	Care Centre notification on 1312 on or before admission; discharge documents collected by the hospital	**5.4.1**
Good Health Series	Prior to discharge – admission exceeding 3 days	Pre-assessment form; admission notes; latest interim bill; daily treatment plan; diagnostic reports; past medical treatment records, where applicable; expected discharge date	**5.4.1**
Good Health Series	Cashless hospitalisation – outside Sri Lanka	Pre-admission form to the AXA Partners Team before a planned admission; immediate contact with the AXA Partners Team in an emergency or for medical evacuation	**5.4.2**
Good Health Series	Reimbursement claims – indoor and OPD	Indoor claim form with member's details; original hospital bills; original paid receipts; Diagnosis Card – a clear copy with hard copies, the original with soft copies. For OPD claims with no hospital bill, the original prescription bearing the doctor's seal	**5.4.3**
Good Health Series	Reimbursement claims – overseas treatment	As for indoor and OPD reimbursement; submit within 90 days of the date of service or treatment	**5.4.3**
Group Life – Corporate Health	Cashless claims	Insurance or membership card; Claim Number from 1312; claim form certified by the hospital; Diagnosis Card; hospital invoice; final detailed bill; clinical documents	**5.5.1**
Group Life – Corporate Health	Indoor claims	Original Diagnosis Ticket; original hospital bill; original cash receipts; claim form; other supporting documents	**5.5.2**

Claim type	Requirement type	Documents required	Section
Group Life – Corporate Health	OPD claims – drugs, investigations and consultations	Original prescription; original cash receipts; consultation receipt	**5.5.2**
Group Life – Corporate Health	Spectacles bills	Original prescription; original cash receipts; consultation receipt	**5.5.2**
Group Life – Corporate Health	Dental bills	Original prescription; original cash receipts; consultation receipt	**5.5.2**
Individual and Group Life – Death	Natural death	Death Certificate; Claimant's Statement; nominee's NIC, Birth Certificate or equivalent; age proof of the deceased if not available at commencement; Marriage Certificate for Spouse Life if not available at inception	**5.6.2**
Individual and Group Life – Death	Accidental death	All natural death documents; Police Report or JMO Report, where applicable; court proceedings with the final court verdict, where applicable	**5.6.2**
Individual and Group Life – Death	Suicide	All natural death documents. Death by suicide within one year of commencement or revival is not covered	**5.6.2**
Individual and Group Life – Death	Missing person	All natural death documents; Presumption of Death Certificate	**5.6.2**
Individual and Group Life – Death	Free Life Cover	Death Certificate; Claimant's Statement; nominee's NIC, Birth Certificate or equivalent; age proof of the deceased if not available at commencement	**5.6.2**
Individual and Group Life – Death	Funeral Expenses Benefit	Certificate of Death or hospital death notice; evidence of relationship where the request relates to a family member	**5.6.2**
Individual and Group Life – Death	Any other requirements – where necessary for sound decision-making	Last Medical Attendance Certificate; Coroner's Inquest Proceedings; Postmortem Report; treatment records, investigations and clinic book records; any other document required for claim settlement	**5.6.2**

Claim type	Requirement type	Documents required	Section
Individual and Group Life – Critical Illness	Critical illness claims	Claimant's Statement; Diagnosis Card; Attending Physician's questionnaire; supporting medical reports, investigations and clinic book; FNAC and histology reports, as applicable	**5.7**
Individual and Group Life – Disability	Disability claims	Claimant's Statement; supplemental attending physician's statement; diagnosis tickets and treatment records; previous treatment records; age proof if not available at policy acceptance	**5.8**