(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

**FORM – A**

**Endorsement**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

No.27, MICH Building,

Sir Razik Fareed Mawatha,

Colombo 01.

I/We, the undersigned, hereby confirm our full understanding and acceptance of the terms, conditions, and instructions detailed in the referenced Bid. We further commit to providing the services specified therein, in strict accordance with the terms outlined, and at the premium rate indicated in our policy.

Additionally, we acknowledge that the Company reserves the right, at its discretion, to reject any or all bids or to accept any portion of a bid that best serves the Company’s interests, without obligation to provide justification. We also understand that the Company is not required to accept the lowest bid.

|  |  |
| --- | --- |
| **Name of the Bidder** |  |
| **Registered Number of the Bidder** |  |
| **Authorized Signatory of the Bidder** |  |
| **Name & Title of the Signatory** |  |
| **Address** |  |
| **Telephone and Fax Nos** |  |
| **Date** |  |
| **Official Seal** |  |

(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

**FORM – B**

**General Conditions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***01*** | ***Maximum Age limit of Dependent***  | **Agreed** | **Not Agreed** | **Remarks** |
|  | The maximum age limit for children should be 25 years and spouse should be 65 years age should be covered. |  |  |  |
| The maximum age limit for parents of the unmarried employees who are under 70 years of age should be covered. |  |  |  |
| ***02*** | ***Reimbursement Time Period*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | The reimbursement of outdoor /indoor bills should be within one(01) weeks’ time. |  |  |  |
| ***03*** | ***Reimbursement Limit:*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | The reimbursement of medical expenses should not be limited to the premium paid. |  |  |  |
| ***04*** | ***Limitations*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | No restrictions on hospital charges and no limitation per event. |  |  |  |
| ***05*** | ***Acceptation of Outpatient Care Prescriptions*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Accept outpatient cover(OPD) prescriptions issued by Government Hospitals or Registered Private Hospitals enlisted with the service provider under hospital seal without Medical Officer Registration Reference. |  |  |  |
| ***06*** | ***Member/ Dependent, Inclusion or Deletion*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Inclusion / Deletion :premium will be charged/refunded on pro rata basis  |  |  |  |
| ***07*** | ***VAT applicability*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Describe the VAT applicability in respect of Outpatient Care (OPD) and Inpatient Care (Hospitalization) claims. |  |  |  |
| ***08*** | ***Claims Process*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Description of the claims process, including documentation required, turnaround time for claim settlements, and whether cashless claims are available. |  |  |  |
| ***09*** | ***Service Levels*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Information on service level agreements (SLAs), customer service availability, and any digital support services.(e.g., apps for tracking claims, health monitoring tools). |  |  |  |
| ***10*** | ***In-house Claim recovery Process***  | **Agreed** | **Not Agreed** | **Remarks** |
|  | The Service Provider should not involve any third party, should only in-house claim settlement process for the purpose of providing Insurance Cover. |  |  |  |
| ***11*** | ***Wellness Programs*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Details of any health and wellness initiatives that will be included, such as preventive care, annual health check-ups, and mental health support. |  |  |  |

Put the mark (**“√”** ) in appropriate Column (Agreed or Not Agreed)

**The Service Provider’s Authorized Person**

Authorized Signatory : …………….…………….………………………………

Designation : …………….…………….………………………………

Date : …………….…………….………………………………

Company Seal:

(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

**FORM – C**

**Scope of Coverage**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***01*** | ***Hospitalization (Inpatient Care)*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | **Room and Board:** Coverage for hospital accommodation, including general wards, private rooms, ETU and ICUs. |  |  |  |
| **Surgical Procedures:** Coverage for all surgical procedures and related hospital costs. |  |  |  |
| **Daycare Procedures:** Coverage for medical treatments that minimum require a six(06) hours hospital stay. |  |  |  |
| ***02*** | ***Outpatient Care (OPD)*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Coverage for general consultations, specialist visits, diagnostics, and prescribed treatments. |  |  |  |
| Coverage for medications prescribed by medical practitioners. |  |  |  |
| ***03*** | ***Critical Illness Coverage*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Coverage for critical diseases such as follows,Cancer, Heart attack, By- Pass surgery, Stroke, Kidney failure, Paralysis, Fulminant hepatitis, Major organ transplant, Primary pulmonary arterial hypertension, Multiple sclerosis, Blindness, Heart valve surgery, Deafness, Surgery to aorta, Chronic liver disease, Major bums, Chronic lung disease, Coma, Loss of speech, Muscular dystrophy, Motor neurone disease, Aplastic anaemia, Benign brain tumour, Angioplasty and Alzheimer’s disease, Medullary Cystic Disease, Systemic Lupus Erythematosus, Major Head Trauma, Terminal Illness, Poliomyelitis, Loss of Independent Existence, Cardiomyopathy, Progressive Scleroderma, Necrotising Fasciitis, Crohn’s Disease, Severe Ulcerative Colitis and etc. |  |  |  |
| This Critical Illness cover should include maximum One Million (Rs.1,000,000/-) subject to two employees per year. (Up to Two Million (Rs.2,000,000/-). |  |  |  |
| ***04*** | ***Maternity Benefits*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Coverage for normal deliveries, cesarean sections, and complications during pregnancy. |  |  |  |
| Coverage for newborns and postnatal care for the mother. |  |  |  |
| During the Pregnancy period treatments both indoor & outdoor cover & Cesarean charges should be paid in full. . |  |  |  |
| ***05*** | ***Dental Care*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Preventive and basic dental care, including fillings, extractions, crowns, dentures and routine check-ups. |  |  |  |
| ***06*** | ***Vision Care*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Vision care, including eye examinations, prescription lenses, and frames. |  |  |  |
| Spectacle Reimbursement should covered under Additional cover excluding indoor & outdoor cover limit. |  |  |  |
| ***07*** | ***Chronic Illness Coverage*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Coverage for chronic diseases such as diabetes, hypertension, asthma, and etc. |  |  |  |
| Long-term treatment coverage for managing chronic conditions. |  |  |  |
| ***08*** | ***Contagious Disease Coverage*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | PCR and Antigen test reimbursement under outdoor treatment cover. |  |  |  |
| Hospitalization covers or inters care expenses cover for contagious disease. |  |  |  |
| ***09*** | ***Ayurvedic Treatment*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Ayurvedic treatments under both outdoor & indoor cover. |  |  |  |
| ***10*** | ***Preventive Healthcare and Wellness Programs*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Annual health check-ups for employees. |  |  |  |
| Wellness programs, fitness initiatives, or mental health counseling. |  |  |  |
| ***11*** | ***Emergency Medical Services*** | **Agreed** | **Not Agreed** | **Remarks** |
|  | Coverage for accidental injuries and related treatments. |  |  |  |

Put the mark (**“√”** ) in appropriate Column (Agreed or Not Agreed)

**The Service Provider’s Authorized Person**

Authorized Signatory : …………….…………….………………………………

Designation : …………….…………….………………………………

Date : …………….…………….………………………………

Company Seal:

(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

**FORM – D**

**Proposed Surgical & Hospitalization Expenses Insurance Cover (Sum Insured)**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

|  |  |  |  |
| --- | --- | --- | --- |
| **Options** | **Indoor limit** | **Outdoor limit** | **Additional limit** |
| **Private Hospital** | **Government Hospital** | **Spectacles** |
| Option 1 | Rs.200,000/- | Rs.3,000/-(per day) | Rs.60,000/- | Rs.20,000/- |
| Option 2 | Rs.200,000/- | Rs.3,500/-(per day) | Rs.70,000/- | Rs.20,000/- |
| Option 3 | Rs.200,000/- | Rs.4,000/-(per day) | Rs.75,000/- | Rs.20,000/- |
| Option 4 | Rs.250,000/- | Rs.4,500/-(per day) | Rs.80,000/- | Rs.20,000/- |
| Option 5 | Rs.300,000/- | Rs.5,000/-(per day) | Rs.85,000/- | Rs.20,000/- |

|  |  |  |  |
| --- | --- | --- | --- |
| **Options** | **Net Premium** **(per Unit)** | **Net Premium****Total****(without Taxes)** | **Grand Total****Premium****(with Taxes/other)** |
| **Individual** | **Family** |
| Option 1 |  |  |  |  |
| Option 2 |  |  |  |  |
| Option 3 |  |  |  |  |
| Option 4 |  |  |  |  |
| Option 5 |  |  |  |  |

**The Service Provider’s Authorized Person**

Authorized Signatory : …………….…………….………………………………

Designation : …………….…………….………………………………

Date : …………….…………….………………………………

Company Seal:

(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

**FORM – E**

**Authorization & Certification**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Authentication**  | **Attached** | **Not Attached** | **Remarks** |
| ***01*** | Insurance providers should provide Registered licensed issued by Insurance Regulatory Commission of Sri Lanka (IRCSL). |  |  |  |
| ***02*** | Should have a minimum of ten(10) years of experience providing employee medical insurance for large organizations, especially government or semi government credit ratings. |  |  |  |
|  | **Current References**  | **Attached** | **Not Attached** | **Remarks** |
| ***01*** | Should provide a minimum number of 10 companies including current reference list of clients with similar or above employee numbers. |  |  |  |
| ***02*** | Should have a wide network of hospitals and healthcare providers across Sri Lanka, including major cities. |  |  |  |
| ***03*** | Should provide a list of test are reimbursed under indoor limit on the recommendation of the doctor without admission to the hospital. |  |  |  |
| ***04*** | Should provide list of Additional/other benefits  |  |  |  |
| ***05*** | ***Network Hospitals***Should provide list of hospitals, clinics, and medical institutions in the provider’s network. |  |  |  |
|  | **Certificates**  | **Attached** | **Not Attached** | **Remarks** |
| ***01*** | Company Profile  |  |  |  |
| ***02*** | Business Registration Certificate |  |  |  |
| ***03*** | Latest Form 15 (Annual Returns)  |  |  |  |
| ***04*** | Latest Audited Financial Accounts  |  |  |  |
| ***05*** | Tax Registration Certificate |  |  |  |
| ***06*** | Relevant any other certifications |  |  |  |

Put the mark (**“√”** ) in appropriate Column (Agreed or Not Agreed)

**The Service Provider’s Authorized Person**

Authorized Signatory : …………….…………….………………………………

Designation : …………….…………….………………………………

Date : …………….…………….………………………………

Company Seal:

(Only on Service Providers Letterhead)

**SURGICAL AND HOSPITALIZATION EXPENSES INSURANCE COVER FOR THE YEAR 2025**

To: Department Procurement Committee,

Ceylon Shipping Corporation Limited,

**FORM – F**

**Financial Criteria**

|  |  |
| --- | --- |
|  | **Financial Criteria** |
| ***01*** | **Payment Terms**Payment may be done after the signing an agreement with the successful service provider as follows: | **Agreed** | **Not Agree** | **Remarks** |
| 40 % from the total contract value will be paid after the letter of award and signing an Agreement within 30 days. |  |  |  |
| 50% will be paid within 60 days from the commencement date of the Policy. |  |  |  |
| 10% balance shall be made within 90 days from the commencement of the policy. |  |  |  |
| ***02*** | **Performance Bond**The selected service provider shall furnish the CSCL with a Performance Bond valued 10 % of the total Contract Value.This Performance Bond shall be submitted on or before signing of Service Agreement.  |  |  |  |
| ***03*** | Demonstrate financial stability and capacity to underwrite the proposed policy. |  |  |  |

Put the mark (**“√”** ) in appropriate Column (Agreed or Not Agreed)

**The Service Provider’s Authorized Person**

Authorized Signatory : …………….…………….………………………………

Designation : …………….…………….………………………………

Date : …………….…………….………………………………

Company Seal: