



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

CLAIM FORM FOR MEDICAL INSURANCE

Issuance of this form does not amount to admission of liability under the policy.

Customer ID

**PLEASE FURNISH THE FOLLOWING INFORMATION CORRECTLY TO ENABLE THE COMPANY TO PROCESS YOUR CLAIM
CLAIM FORM SHOULD BE COMPLETE IN ALL RESPECTS INCOMPLETE WOULD DELAY THE PROCESSING
COMPLETE THE FORM IN CAPITAL LETTERS**

Name of the Insured
First Name Middle Name Last Name

Name of the person for whom the claim is made
First Name Middle Name Last Name

Relationship with the Insured

Address for Communication

City/Taluk District State Pin Code

STD Code Phone Cell

Policy Number E-mail

Period of Insurance : From To Sum Insured

Previous Policy No/s. with Star Insurance : From To ID Card No.

With any other insurers : From To

A) Nature of Disease/ Illness Contracted :

Brief History of Disease/Illness : Date Time

B) In case of injury

(i) When did the accident happen

(ii) Where did the accident happen

(iii) Brief Particulars of the accident

(iv) Whether the said accident was reported to the Police?

(v) If Yes, please furnish the FIR copy with particulars

(vi) If accident was not reported, Reason for not reporting

(vii) MLC/AR copy from the hospital.

Name of the Hospital

Address

City/Taluk District State Pin Code

Date & Time of admission Date & Time of discharge Tel

MEDICAL CERTIFICATE TO BE FILLED IN BY TREATING DOCTOR

1. Name of the Patient	Age :
2. Admission Date and Time	Discharge Date and Time
3. Name of Surgeon / Physician	
4. Diagnosis	
5. (a) Date of First Consultation of the Doctor	
(b) Previous Consultation before hospitalisation	
6. (a) With What complaints was the patient admitted for:	
(b) Since when was the patient suffering from the said complaints	
7. Past History of the Patient (if any) with the duration of illness	
8. Whether the present ailment is a complication of Pre-existing disease?	
If yes, please specify the disease (or) complication of any previous surgery done? If yes, please specify details.	
9. Whether the disease/disorder is congenial in nature?	
10. Nature of Surgery/treatment given for present ailment	
11. (a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No.	
(b) No. of in - patient beds in the Hospital (including ICU)	
(c) Whether the Hospital is having fully equipped Operation Theatre of its own/qualified nurses round the clock/qualified doctors round the clock?	

Signature of the Doctor with Seal

Date

Hospital Seal :