CLAIM FORM FOR PERSONAL ACCIDENT INSURANCE

The issue of this form is not to be taken as an admissibility of liability.

1. Details of The Insured / Proposer

Claim No. :

Name : _____ Address : _____

_____

_____

City : _____ Pincode : _____ Phone No. : _____

2. Details of the Policy

Policy No.:_____ Policy Period : From _____ To _____

3. Details of Injured Person / Deceased Person

Name : _____ Gender: Male ☐ / Female ☐ / Third Gender ☐ Age: ____ Date Of Birth :_____

Relationship with the Insured : _____ Occupation :_____ Address :_____

_____ City :_____ Pincode : _____ Phone No. _____

4. Details of Insurance History

Did the insured have any other Accident insurance on his life : Yes ☐ / No ☐

If Yes, State the name of he Insurance Company and details /Status of the Claim/s Made _____

_____

5. Details of Accident

Date of Accident: _____ Time of Accident : _____ AM / PM. Place of Accident : _____

Particulars of the Accident : _____ Whether the accident reported to the Police : Yes ☐ / No ☐

If Yes, Details of FIR and Police Station _____ If not, Please give reasons_____

6. Details of Hospitalization

a) Date of Admission & Time : _____ & _____ AM / PM. Date of Discharge & Time :_____ & _____AM / PM.

b) Name of the Hospital and address where admitted _____

7. Details of Claim

a) Hospitalization Claim ☐ : Amount Claimed : _____ b). Outpatient Claim ☐ : Amount Claimed :_____

c) Death Claim ☐ : Date of Accident:_____ Date of Death : _____ Details of Nominee : _____

Relationship of nominee with the Deceased _____

d) Permanent Total Disablement ☐ : _____ Nature of Percentage : _____

e) Permanent Partial Disablement ☐ : _____Nature of Persentage : _____

f) Temporary Total Disablement / Weekly Benefit ☐ : _____

Date of Accident : _____ Date of Resuming Duty / Fitness : _____ (Attach Fitness Certificate).

No. of Days confined to bed : ____ Days : From _____ To _____ No, of Days confined to House :____ days : From _____ To _____

STAR Health And Allied Insurance Company Limited

Registered Office:No.1, NewTankStreet, ValluvarKottam High Road, Nungambakkam, Chennai-600034 | Phone:044-28288800

Corporate Office : No. 148, Acropolis, Dr. Radha Krishnan Salai, Mylapore, Chennai - 600 004 | Corporate Office - Claims Dept. : No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014 | Phone : 044 - 4788 6666 | Email : support@starhealth.in | Website :www.starhealth.in | CIN:L66010TN2005PLC056649 | IRDAI Regn.No. : 129

g) Education Grant : _____ No. of Children:____Names(s) of Childe Children: _____

_____

h) Ambulance Charges/ Transportation Expenses of Mortal Remains : _____ Details: _____

i) Travel Expenses For One Relative : _____Details:_____

j) Vehicle and/or Residence Modification : _____ Details: _____

k) Purchase of Blood : _____ Details: _____

l) Medical Expenses Extension :_____ Amount Claimed: _____

m) Hospital Cash : _____ Date of Admission:_____ Date of Discharge: _____

n) Home Convalescence : _____Details:_____

8. Where and when can a Medical Officer of this Company visit you, if necessary? _____

9. Details of Insured / Claimant's Bank Account

Name of the Account Holder : _____Name of the Bank and Branch : _____ Bank Account

Number : _____IFSC Code : _____ PAN Number (Attach Copy of Pan Card,

Aadhar Card, Cancelled Cheque Leaf): _____

Declaration of the Insured / Claimant :

I hereby declare that the foregoing statements are made by myself and are true in all respects and that I have not attempted to conceal from the company anything which it ought to be made acquainted and also that I have not abstained from any usual occupation longer than absolutely necessary and I agree that if I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, Concealment or untrue averment whatever the policy shall be void and my right to compensation forfeited and am willing, if required to make a statutory declaration before a justice of the truth of the whole of the foregoing statement or any other statement i may make a connection with this claim.

Witness: _____

Name : _____

Date:_____ Signature of the Insured / Claimant

Document Check List for Personal Accident Claim Submission

Claim form to be duly filled and signed along with the Medical Certificate.
Note: The Company reserves the right to call for additional documents wherever required.

HOSPITALIZATION CLAIM Original Discharge Summary (wherever applicable) Original Medical Reports Original Invoices/Bills, Original Payment Receipts Prescriptions Bonafide Certificate, if required Employment Status, if required	**FOR DEATH CLAIMS** Death Certificate Post-mortem Certificate, if conducted FIR (wherever required) Police Investigation report (wherever required) Viscera Sample Report (wherever required) Legal Heir Certificate (wherever required) No Objection affidavit (wherever required)	**FOR DISABILITY CLAIMS:** Certificate from Government doctor not below the rank of Civil Surgeon, confirming the disability and its percentage. Discharge Summary Certificate of employer stating the period of absence / Attendance Certificate / Fitness Certificate FIR / MLC / AR / Copy Prescriptions IT Proof Investigation Reports
TRANSPORTATION OF IMPORTED MEDICINES: Prescription of the treating doctor with confirmation that the medicine is not available in India. Original receipt for the freight incurred for import of the medicine, along with a copy of invoice	Vehicle and / or residence modification Certificate from the doctor confirming the Disability and the requirement of modification Estimate from Workshop Cash receipt for having carried the vehicle modification Estimate from civil engineer Cash receipt for completion of the civil work modification	Medical expenses due to accident: Original Discharge Summary (wherever applicable) Original Medical Reports Original Invoices / Bills Original Payment Receipts
PURCHASE OF BLOOD: Original receipt for purchase of blood (wherever applicable)	Ambulance charges / transportation expenses of mortal remains Death Certificate or Proof of hospitalisation Proof of utilized services of either Ambulance or Mortuary Van	Travel expenses for one relative Proof of expenses incurred (original)
Hospital Cash and Home Convalescence Discharge Summary (Where original is required for other purposes, a certified copy may be submitted) Recommendation by the treating doctor for appointing an attendant at home for continuation of treatment.	**EDUCATIONAL GRANT** Bonafide Certificate Certificate from the school in which the child / children is / are studying, confirming their studies	

MEDICAL CERTIFICATE (To be filled by treating Doctor)

a) Name of the Claimant	
b) Gender & Age	
c) Date of Accident	
d) Date of Admission & Discharge	
e) Nature and Cause of Accident	
f) Date on which you first attended the Claimant for this injury	
g) Is the Claimant suffering from any disease or illness apart from the injury and is there any illness or circumstances which may tend to retard recovery ? Ifso give particulars	
h) Past Medical History	
i) Present Condition	
j) Is disablement Permanent ? If so, what is the percentage of disability	
k) Nature and Extent of Injury	
l) Has the Claimant been totally prevented from attending to normal duties ? If so how long?	
m) Temporary Total Disability / Weekly benefit - Period of disability	
n) No. of Weeks	From To
o) Whether fit to Perform Normal Duties	Yes ☐ / No ☐

Having personally examined the above named claimant, I certify that the above statements are correct and that the injured person /claimant is necessarily disabled by the accident referred to.

Signature : _____

Name : _____

Qualification : _____

Address: _____

_____

_____

_____

CLAIM NO. _____

PATIENT ADMISSION NO. / IP NO. /MRD NO. _____

To: (Name of the Hospital & Address)

_____

_____

_____

Dear Sirs,

Re: AUTHORISATION TO STAR HEALTH AND ALLIED INSURANCE CO. LTD.,

I have undergone treatment for

_____

from _____/ _____ / _____ to_____/ _____ /_____ in your Hospital.

I hereby authorize **M/s. Star Health and Allied Insurance Company Ltd.** and its representatives, who is my Health Insurer to seek any medical information/records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. Incase they seek any such information/ records / indoor case papers, kindly oblige.

Thanking You

Yours Faithfully

_____

(Signature of the Insured/Claimant)

Address of the insured :

_____

_____ Date: _____

_____ Place:_____

STAR Personal & Caring | Health Insurance

SPC-16-07-19-50K-PO: 035

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