

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.
- Cash receipt for payment made to the attendant

Note: The Company reserves the right to call for additional documents wherever required



SQPIL - 30.10.15 - 25K - PO - 079



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
Corporate Office - Claims Dept. : No.15, Sri Balaji Complex, Whites Lane, Royapettah, Chennai - 600 014.
CIN : L66010TN2005PLC056649 Email : info@starhealth.in Website : www.starhealth.in IRDAI Regn. No: 129

CLAIM FORM FOR ACCIDENT CARE INSURANCE

Name of the Insured [in full] _____

Contact no: _____

Mail id : _____

Name of the injured Person _____

Name of the Nominee _____

Age of the Nominee _____

Relationship of the Nominee with the injured person : _____

Address in full _____

Profession or occupation _____

Age at last birthday _____

Employee Number (If applicable): _____

Policy No. _____

Sum Insured _____

Table of Cover Opted _____

Period of Insurance _____

Date and time of Accident _____

Place of Accident _____

Circumstances of the accident
(Give a brief description) _____

Nature of Injury _____

Nature of Disablement _____

Extent of disablement (% of disability) _____

No. of days confined to bed : _____ days From _____ To _____

No. of days confined to house : _____ days From _____ To _____

1.Where and when can a Medical Officer of the Company visit you, if necessary?

Name(s) of the Child/Children (For educational grant)

Age _____

Age _____

Studying in _____

1) _____

2) _____

Details of Transportation Expenses of Mortal Remains _____

Travel Expenses for Relative : Rs. _____

Please attach the documents as detailed in page two _____

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 Peace of the truth of the whole of the foregoing statement or any other statement I may make a connection with this claim.

Witness: _____

Signature of the Insured / Assignee

Name _____

Date :

Documents to be submitted are :

Duly completed claim form and

For Death Claims:-

- Death Certificate
- Post-mortem Certificate, if conducted
- FIR (wherever required)
- Police Investigation report / Panchanama (wherever required)
- Viscera Sample Report / Chemical Analysis report (wherever required)
- Forensic Science Laboratory report / (wherever required)
- Legal Heir Certificate
- Succession Certificate (wherever required)

For Disability Claims:

- Certificate from Government doctor not below the rank of Civil Surgeon, confirming the disability and its percentage.

Note: The Company authorized doctor may examine the insured if required

- Certificate from the employer confirming leave of absence from duty

For Educational grant

- Death Certificate
- Certificate from the school in which the child / children is/are studying, confirming their study

For Ambulance charges / transportation expenses of mortal remains

- Death Certificate or
- Proof of hospitalisation
- Proof of utilized services of either Ambulance or Mortuary Van

For Travel expenses for one relative

- Proof of expenses incurred (original)

For 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 modification
- Certificate from the doctor confirming the Disability and the requirement of modification
- Estimate from civil engineer
- Cash receipt for completion of the civil work modification

For Purchase of Blood

- Original receipt for purchase of blood (wherever applicable)

For Transportation of Imported Medicine:

- 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

For Claim under Optional Benefits:

Medical expenses extension:

- Original Discharge Summary (wherever applicable)
- Original Medical Reports
- Original Invoices/Bills
- Original Payment Receipts