STAR Personal & Caring Health Insurance
The Health Insurance Specialist

STAR HEALTH AND ALLIED INSURANCE COMPANY LTD
Corporate Office - Claims Dept. : No.15, Balaji Complex,
Whites Lane, 1st Floor, Royapettah, Chennai - 600 014
www.starhealth.in | support@starhealth.in

Reimbursement Claim Form - Part A

All reimbursement claims have to be intimated to us immediately (before discharge). Claim documents should be submitted within 30 days from the date of discharge. Please answer all the questions. Use additional sheets, if required and attach the documents as indicated. Please note that the list of documents mentioned is an indicative list, we may ask for any other documents to process the claim. The issuance of this form does not imply Admission of Liability.

Claim Number	

Claim Type (Tick Appropriate Box)

- ☐ In-Patient Treatment
- ☐ OPD Treatment
- ☐ Health Checkup
- ☐ Hospital Cash
- ☐ Pre-Hospitalization Expenses
- ☐ Day Care Procedures
- ☐ Domiciliary Hospitalization
- ☐ EMI Protect
- ☐ Post-Hospitalization Expenses
- ☐ Maternity Cover
- ☐ Critical Illness

Details of Proposer

Policy Number		**Policy Period**	
Proposer Name		**Customer ID**	
Employee Name (in case of Group Policy)		**Employee ID No (in case of Group Policy)**	
ID Proof Type		**ID Proof No. (Last 4 Digits if Aadhaar)**	
CKYC Number		**PAN Card No.**	
Address		**City**	
Registered email ID		**District**	
Registered Mobile No.		**State**	
WhatsApp Number		**Pin code**	

Details of Insured Patient in respect of whom claim has been made

Insured Patient Name			**Gender**		
Date of Birth/Age			**Relationship with Proposer / Employee**		
ABHA ID No.			**ID Proof Type**		
Star Health / TPA ID Card No.			**ID Proof No. (Last 4 Digits if Aadhaar)**		
Hospitalisation Due to	☐ Illness ☐ Maternity ☐ Injury		**Date (if accident)**	DD/MM/YYYY **Time**	
Place of Accident			**Reported to Police (if Accident)**	☐ Yes	☐ No
If not reported to Police give reasons					

Details of Insurance History

Currently are you insured by any other COMPANY's Health Insurance Policy or by any other Star Health Insurance Policy

☐ Yes ☐ No

If Yes, INSURER Name		**Policy Number**	
Policy Period		**Sum Insured**	

Has this hospitalisation bill been Claimed with any other Insurance Company or Insurance Schemes? If Yes, please enclose settlement letter

☐ Yes ☐ No

IRDAI Regn. No: 129
CIN : L66010TN2005PLC056649
Toll free Phone No: 1800 425 2255 | 1800 102 4477

Details of Treatment Expenses Claimed with STAR Health Insurance

Details of Expenses Claimed	Amount	Details of Expenses Claimed	Amount
Hospitalization Expenses		Ambulance Charges	
Pre-Hospitalization Expenses		Lump-Sum Benefit	
Post - Hospitalization Expenses		Critical Illness Benefit	
Health Checkup Expenses		Others	
Total		**Total**	

Details of Bill Enclosed

Sl. No.	Bill No.	Date	Issued by	Details of Expenses Claimed	Amount

Note: In case of more details, please attach separate sheets

Please submit the required Mandatory Documents listed in the checklist for prompt claim settlement, wherever applicable

List of Mandatory Documents to be submitted	Yes / No	List of Mandatory Documents to be submitted	Yes / No
Duly filled and signed Claim Form		Doctor's Prescription for Admission, Medicine, investigations, Surgery (Originals)	
Discharge Summary (Originals)		Investigation / Diagnostic Reports Including CT / MRI / USG / HPE / ECG etc.,) (Originals)	
Hospital Final Bill with breakup and Receipts (Originals)		Invoice / Sticker for the implants used in the treatment.	
Doctor Consultation Bills (Originals)		Proposer's Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement - Self Attested	
Pharmacy / Investigation / Diagnostic Bills (Originals)		Death Certificate	
Sonography Report - in case of Maternity Claim (Originals)		Legal Heir / Succession Certificate if Nominee is not Registered under the Policy (in case of Proposer's Death)	
USG / X-Ray / MRI / CT Films (Original)		Affidavit-NOC from Legal Heirs in Stamp Paper certified by Notary Public (In case of settlement to Legal Heir)	
Pre & Post - Hospitalisation Bills (Originals)		Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death) - Self Attested	
Proposer's ID Proof, Address Proof, PAN Card & Photo (If CKYC not registered) Self Attested		Medico Legal Case (MLC) / Accident Report (AR) / (In case of Accident)	
ID Card issued by Employer (in case of Group Policy) Self Attested		First Information Report (FIR) in case of Accident	

Proposer's Bank Account Details

Bank Name		**Bank Account Holder Name**		**IFSC Code**	
Bank Branch Name		**Account Type**		**Account Number**	

☐ I / We understand that any payment related to Premium Refund / Claim Amount will be directly deposited to my aforesaid Bank Account. Verification of Bank Account Details is a mandatory requirement for NEFT transactions. Please enclose either a Cheque Leaf or Bank Passbook

Declaration by the Proposer / Claimant

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post hospitalisation claim, if any. I / We authorise Star Health Insurance Company / TPA to contact me / us through SMS / Email / WhatsApp for any update on this claim

I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/ email address. The list of acceptable documents can be referred from website (Download > AML/KYC).

I hereby authorize Star Health & Allied insurance Co to use any information/data provided in any of the documents submitted for this claim for the purpose of research/training/analytics/ investigations/case studies and to ensure that such information/data do not go outside the insurer and its authorized representatives and also to be compliant under the relevant laws and regulations and without prejudice to my Personal data privacy.

Date		**Signature of the Proposer / Claimant**	