STAR HEALTH AND ALLIED INSURANCE CO. LTD.

Regd. & Corporate Office :
1, New Tank Street, Valluvar Kottam High Road, Nungambakam, Chennai - 600 034.
Phone : 044-28263300 / 28288800 E- mail : info@starhealth.in

CLAIM FORM FOR TRAVEL PROTECT / INSURANCE

(The furnishing of this form should not be construed as admission of liability)

1.	Name of the Insured Person	Mr. / Mrs.
2.	Home address in India	
3.	Address for communication (overseas)	
4.	Telephone / Mobile / E-mail ID	
5.	Date of Birth	____ ____ 20____ DD MM YY
6.	**DETAILS OF POLICY :** Policy number Date of commencement of Trip Date of return to India	
7.	Total claim amount	

(Please Submit original bills / receipts in case of reimbursement)(applicable to all policy sections)

8.	**Policy section relating to medical** (i) **Emergency Medical Expenses:** **A) If treated as Out-Patient:** i) Date of Treatment ii) Nature of Ailment/Complaint iii) Name of Doctor/Clinic/Hospital **B) If treated as In-Patient;** i) Date of admission ii) Date of Discharge iii) Date/s of Review iv) Nature of Ailment/Complaint v) Name of Hospital vi) Name of the Attending Doctor vii) Has the authorization from the Assistance Company been obtained? (Pls submit copies of investigation reports, discharge summary, prescription and original bills/receipts) **II) Emergency Medical Evacuation** a) Has the authorization from the Assistance Company been Obtained? b) If so, provide the reference number? **III) Emergency Dental Expenses** **<u>Dental :</u>** a) Date of accident b) Briefly describe the accident c) Name of the Dr. / Nursing Home / Clinic	

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9.	**Transportation of Mortal Remains :** a) Inform the assistance company & Obtain authorization : b) Name of the claimant : c) State cause of death of the Insured Person :	
10.	**Personal Accident :** a) Please state the place, time and date of accident : b) Give a brief description of the accident : c) Was there any hospitalization? If so, Provide the name of the hospital, the duration. d) The cause of death (for death claims) : e) The nature and extent of Disability (in case of disability claims) : f) In case of automobile accident please give : (i) Number of Offending Vehicle (ii) Details of Police Compliant given	
FOR MEDICAL AND PERSONAL ACCIDENT CLAIMS PLEASE OBTAIN THE RELEVANT PORTION OF THE FORM DULY COMPLETED BY THE ATTENDING DOCTOR (FOR REIMBURSEMENT CLAIMS)		
11.	**Loss of Checked in Baggage and Delay of Checked in Baggage** : a) Date of occurrence of claim : b) Trip destination : c) Time, date and place of loss/delay : d) Brief details of the circumstances of loss : e) Was the matter reported to the carrier? If so, a copy of the letter and the carrier's response together with the Property Irregularity Report : f) Details of amenities provided by airlines : g) Details of any emergency purchase made (give original bills) :	
12.	**Loss of Passport:** a) Passport Number and date of issue : b) Has the loss been intimated to the police? (please attach the police report/complaint) : c) Describe the circumstances of loss giving details about the time and place of loss : d) Details of claim (please furnish the original bills / receipts for expenses incurred for obtaining a new passport / alternate travel documents) :	
13.	**Flight Delay :** a) Any written information from the carrier about the cause of delay ? : b) Please provide details of compensation received from the carrier :	
14.	**Missed Departure / Connection:** a) Please state the circumstances leading to your missing the flight. : b) Please provide details of the alternative arrangement made by the carrier. :	
15.	**Hijack Distress :** a) Please give full details of the episode : b) Provide details of correspondence or / communication received from the carrier :	
16.	**Trip Cancellation / Interruption:** a) Please state the reasons leading to Cancellation / Interruption of your trip (attach proof) : b) Provide copy of communication/s with the carrier and details or refund received from the carrier :	

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17.	**Personal Liability :** a) Details with date, place and time of occurrence of the event leading to legal liability : b) Did you obtain any written statement from witnesses to the occurrence? If so, attach proof : c) Are you convinced that prima facie that you are liable at law? No compromise or out-of court settlement to be made. :	
18.	**Substitution of employee :** a) State the reasons why the substitute employee should be deputed. : b) Name of the substitute employee, proposed travel date, destination : c) Please provide the Assistance Company reference number in respect of the employee who reported sick? : d) Details of expenses incurred :	
19.	**Study Interruption :** a) Give in detail the circumstances leading to interruption of your studies : b) In case of your illness please furnish certificate form the treating doctor : c) Has the Institution in which you are studying been informed - please provide copies of correspondence : d) Has the institution given any concession in fees? Please provide detailed break-up along with proof :	
20.	**Compassionate visit :** a) In case of your illness please furnish certificate from the treating doctor : b) Detail the circumstances leading to your visit to India / your family member visit to your place of study ? :	
21.	**Sponsor Protection :** a) Please provide the name of the sponsor : b) Date, time and place of death : c) Cause of death (enclose death certificate) : d) Furnish details of fees paid/payable with proof :	
22.	**Bail Bond :** a) Date, place and time of detention : b) Provide a detailed account of the circumstances leading to arrest : c) Is there any witness to the event? If so, has any written statement from the witness taken? Please provide all necessary legal proof. :	

PLEASE ATTACH SEPARATE SHEET/S FOR YOUR ANSWERS WHEREVER NECESSARY.

Please complete the claim form in all respects. Read the instructions given along with the policy carefully before filling in the form. Attach all the relevant documents in support of your claim to avoid delay.

I declare that to the best of my knowledge all particulars contained in this form are true.

I authorize any hospital or medical-care institution, physician or any other person who has rendered medical services and support with respect to any injury or sickness suffered by the insured person to furnish to the insurance Company and or its agents or representatives all information necessary for the purpose of determining eligibility for benefits payment under the policy.

Date :

Place: Signature of the Claimant

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QUESTIONNAIRE TO BE COMPLETED BY THE ATTENDING DOCTOR

(in case of reimbursement claims and accident claims only)

1.	Name of the insured person	:	
2.	Age	:	
3.	Occupation	:	
4.	Address	:	
5.	Please state the nature of disease / accident in detail	:	
6.	Does the cause of disease / accident as stated by the Insured Person tally with your findings ?	:	
7.	Do you believe that the injuries / disease is traceable to any injuries / sickness ?	:	
8.	Please mention the past history of the patient, as informed to you.	:	
9.	Was the patient hospitalized during the current occurrence ?	:	
10.	Furnish the details of treatment provided	:	
11.	Was the patient under the influence of intoxicants or drugs ?	:	
12.	Has the accident been reported to police ?	:	
13.	How long have you been treating this patient ?	:	
14.	Is the patient disabled ? If so, please give details with the degree of disability in your opinion	:	
15.	Name of the doctor and his address	:	

Dated :

Place :

Signature of the doctor
with seal

SPC- 30.04.12-40K-PO : 009