



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

Name of the Insured

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of the person for whom the claim is made

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Relationship with the Insured

Address for Communication

City/Taluk District State Pin Code

STD Code Phone No. Fax Cell

Policy Number Period of Insurance : From To

Sum Insured

ID Card No. E-mail :

Nature of Disease/ Illness Contracted or Injury Sustained :

Date of Injury Sustained for Disease/ Illness First Detected

D	D	M	M	Y	Y
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Name of the Hospital

Address

City/Taluk District State Pin Code

Date & time of admission

Date & time of Discharge

Name of the Medial Practitioner

Address

City/Taluk District State Pin Code

Qualification Regn. No.

Have you been insured under any Medclaim Scheme of any other insurance Company. Y N

If YES, XEROX Copies of previous years' policies must be enclosed.

Date of commencement of very first insurance for the claimant with continuous insurance Coverage : From To

Have you preferred any claim for the same insured under the Medclaim Policy earlier, if so give details viz :

(a) Previous claim No & Office

(b) Diagnosis

