

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office :

1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.

CLAIM FORM FOR TRAVEL PROTECT / SAFE INSURANCE

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

1.	Name of the person claiming	Mr. / Mrs.
2.	Home address in India :	12. Loss of Checked in Baggage and Delay of Checked in Baggage;
	number to respect of the employee type resourced sec	a) Date of occurrence of claim
	(i) Details of expenses incurred .	b) Trip destination.
	Study Interruption:	c) Time, date and place of loss/delay
3.	Address for communication :	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
4.	Telephone / Mobile / E-mail ID :	10 Details of claim 13 Loss of Passports
5.	Occupation :	a) Passport Number and date of issue
6.	Date of Birth :	DD MM YY
7.	Type of policy :	Travel Protect (Individual) / Corporate Travel Protect / Family Travel Protect / Student Travel Protect / Travel Safe
8.	DETAILS OF POLICY :	d) Details of claim (please furnish the original bills r
	Policy number :	receipts for expenses incurred for obtaining a net passport / alternate travel documents)
	Date of commencement of Trip :	14. Flight Delay :
	No of days :	a) . Any written information from the carrier
71	Proposed Date of return to India	about the delay ?
9.	POLICY SECTION RELATING TO MEDICAL :	b) Preuse provide details of compensation received from the carrier
	i) Emergency Medical Expenses	15. fillesed Departure / Connection:
	ii) Emergency Medical Evacuation iii) Emergency Dental Expenses	at Please state the circumstances leading to
	a) Has the authorization from the Assistance	your missing the flight.
	Company been obtained ?	b) Please provide details of attenuative
	b) If so, provide the reference number :	OUR ANSWERSELENGERS PROPERTY AND
- 41	c) When did the sickness symptoms	o) Details of claim
	first occurred ?	a) Please give full details of the episods
	d) Have you suffered from the same illness before ?	b) Provide details of correspondence or /
	e) If so, provide the name and address of the physician whom you consulted before and when ?:	hermo aff, most beviaces notisolaumoo
10		at Please state the religions leading to Cancellation
10.	Transportation of Remains :	Interruption of your trip (attach proof)
	a) Name of the claimant :	b) Provide copy of communication/s with the carrier
	b) State cause of death of the Insured Person :	tradelation and detailengement and received from the carrier

11.	Personal Accident :	A
da	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) :	CLAIM FORM FOR TRAVEL
	MEDICAL AND PERSONAL ACCIDENT CLAIMS PLEAS THE ATTENDING DOCTOR (FOR REIMBURSEMENT CLA	
12.	Loss of Checked in Baggage and Delay of Checked in Baggage :	
	a) Date of occurrence of claim :	
3.	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 claim :	
13.	Loss of Passport:	# Telephone / Mobile / E-mail ID
	a) Passport Number and date of issue :	
	b) Has the loss been intimated to the police ? (Please attach the police report/complaint) :	
n stat	c) Describe the circumstances of loss giving details about the time and place of loss :	
8.	d) Details of claim (please furnish the original bills / receipts for expenses incurred for obtaining a new passport / alternate travel documents) :	
14.	Flight Delay :	dut to memecatamino to area
10	a) Any written information from the carrier about the delay ?	
11	b) Please provide details of compensation received from the carrier :	
15.	Missed Departure / Connection:	i) caretyericy medical Expenses
12.	A) Please state the circumstances leading to your missing the flight.	
93	b) Please provide details of alternative arrangement made by the carrier.	e) Has the authorization from the Assistance Company been obtained ?
10	c) Details of claim :	
16.	Hijack Distress:	>supplyings assumes our one north. (a
	a) Please give full details of the episode :	
	b) Provide details of correspondence or / communication received from the carrier :	
17.	Trip Cancellation / Interruption:	of it on provide the name and address of the physician whom you consulted before and when
	a) Please state the reasons leading to Cancellation / Interruption of your trip (attach proof) :	Digestation of Remains :
	b) Provide copy of communication/s with the carrier and details or refund received from the carrier :	a) Name of the claimant is at Name of the claimant is at the cause of death of the through Person

18.	Personal Liability:	A
da	a) Details with date, place and time of occurrence of the event leading to legal liability	ON IS TARROSTAR HEALTHING
	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.	MANAGEMENT OF THE STREET OF TH
19.	Substitution of employee :	AND ASSAULT ANSWERS NOT THE REAL PROPERTY OF THE PERSON OF
	State the reasons why the substitute employee should be deputed.	OUESTIONNAIRE TO BE COMP
	b) Name of the substitute employee, proposed travel date, destination	1. Name of the injured person
	c) Please provide the Assistance Company reference number in respect of the employee who reported sick ?	2. Age
	d) Details of expenses incurred	3. Occupation
20.	Study interruption :	
	a) Give in detail the circumstances leading to interruption of your studies	4. Address
	b) In case of your illness please furnish certificate from the treating doctor	:
	c) Has the Institution in which you are studying been informed - please provide copies of correspondence	5 - Please state the nature of disease / secide /
	d) Has the institution given any concession in fees ? Please provide detailed break-up along with proof	in detail
21.	Compassion visit :	6. Does the cause of disease / accident as of to
	a) In case of your illness please furnish certificate from the treating doctor	by the Insured Person lally-with your finding
	b) Detail the circumstances leading to your visit to India / your family member visit to your place of study?	Do you believe that the injuries / disease is traceable to set injuries / sidmess
22.	Sponsor Protection :	
	a) Please provide the name of the sponsor	8. Please mention the past history of the patie :
	b) Date, time and place of death	9. Was the patient hospitalized during
	c) Cause of death (enclose death certificate)	the current occurrence ?
	d) Furnish details of fees paid/payable with proof	:
23.	Ball Bond :	10. Furnish the details of freatment provided
	a) Date, place and time of detention	11. Was the patient under the influence of
	b) Provide a detailed account of the circumstances leading to arrest	Intoxicants or drugs ?
	c) Is there any witness to the event? If so, has any written statement from the witness taken?	12 Has the accident been reported to Police ?
	Please provide all necessary legal proof.	13. How long have you been treating this patient

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.

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Place:

Signature of the Claimant



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office :

1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.

Phone: 044-28263300 / 28288800 E-mail: uw@starhealth.in

QUESTIONNAIRE TO BE COMPLETED BY THE ATTENDING DOCTOR

(in case of reimbursement claims and accident claims only)

1.	Name of the injured person :	b) Name of the substitute employee, proposed (889) travel data, destination
2.	Age :	c) Please provide the Assistance Company referen- number in respect of the employee who reporter
3.	Occupation :	d) Datails of expenses incurred
4	Address	20. Study Interruption :
4.	Address :	a) Give in detail the circumstances leading to interruption of your studies
		b) In case of your linese please furnish certificate from the treating doctor
	together with the Property Irregularity Report. William	c) Has the Institution in which you are studying bee
5.	Please state the nature of disease / accident	d Has the institution given any concession in fees
	in detail :	d) Has the institution given any concession in fees Please provide detailed break-up along with proc
6.	Does the cause of disease / accident as stated	21. Compassion visit:
	by the Insured Person tally with your findings ? :	a) In case of your illness please furnish cerfficate from the treating doctor
7.	Do you believe that the injuries / disease is traceable to any injuries / sickness?	b) Detail the circumstances leading to your visit to your family member visit to your place of study "
	traceable to any injuries / sickless:	22. Sponsor Protection :
8.	Please mention the past history of the patient. :	a) Please provide the name of tire sponsor
9.	Was the patient hospitalized during	b) Date, time and place of death.
	the current occurrence ?	Cause of death (enclose death certificate)
10.	Furnish the details of treatment provided :	23. Baji Bond :
11.	Was the patient under the influence of	a) Date, place and time of detention
	intoxicants or drugs ? :	b) Provide a detalled account of the circumstances leading to arrest
12.	Has the accident been reported to Police ?	(4) "Is there any witness to the event? If so, has any witten statement from the witness taken?
13.	How long have you been treating this patient? :	Please provide all necessary legal proof.
14.	Is the patient disabled ? If so, please give details with the degree of disability in your opinion :	PLEASE ATTACH SEPERATE SHEET/S FOI
15.		form, Attach all the relevant documents in support of your o
		I declare that to the best of my knowledge all particulars on
Date		
		policy
Plac		Signature of the doctor
		with seal