

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. Phone: 044 - 2828 8800 CIN: L66010TN2005PLC056649

Email: support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE

POLICY PART - C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR / INSURER / HOSPITAL ·

a. Name of TPA / Insurance company :		AND ALLIED INSURANCE	
b. Toll free phone number :			
c. Toll free fax :			
d. Name of Hospital :			
I. Address ii. Rohini ID iii. e-mail id	TO BE FILLED	BY INSURED/PATIENT	
A. Name of the Patient :			
B. Gender:	Male	Female	Third Gender
C. Age:		(Years) / (Month)	
D. Date of Birth :		(DD) / MM / YYYY)	
E. Contact number :	_		
F. Contact number of attending Relative :			
G. Insured Card ID number :			
H. (a) PAN Number of the Proposer	(b) CK	YC of the Proposer (If Available)	
I. Policy number/Name of Corporate : J. Employee ID :	_		
Currently do you have any other mediclaim / I. Company Name :	health insurance :	Yes	No
ii. Give Details :			
L. Do you have a family Physician :		Yes	No No
M. Name of the family Physician :			
N. Contact number, if any :			
O. Current Address of Insured Patient :			
P. Occupation of Insured Patient:			
		(PLEASE COMPLETE I	DECLARATION OF THIS FORM)

(PLEASE COMPLETE DECLARATION OF THIS FORM)

Note: In case, the customer is not CKYC registered, please collect the KYC Records - Proof of ID, Proof of Address, Photo & PAN Details from the Customer, while sending this request.

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A.	Name of the treating Do	ctor:					
В.	Contact number::						
C.	Nature of illness/Disease	e with presenting complaint :					
D.	Relevant Critical Finding	ıs:					
E.	Duration of the present a	ailment				_ Days	
	iv. Date of Fi	rst consultation				- (DD/MM/Y'	YYY)
	v. Past histo	ry of present ailment, if an					
F.	Provisional diagnosis:	10 code					
G.	Proposed line of treatment. I. II. III. IV. V.	ent: Medical Management Surgical Management Intensive care Investigation Non-allopathic treatment	(((())))			
Н.	If investigation and/or M	edical Management, provide deta	ails:				
	i.	Route of Drug Administration	1				
I.	If surgical, name of surg	ery: i. ICD I0 PCS code					
J.	If other treatment, provid	de details:					
K.	How did injury occur:						
L.	In case of accident:						
		 i. Is it RTA ii. Date of injury iii. Report to Police iv. FIR NO v. Injury/Disease caused due to vi. abuse/alcohol consumption vii. Test conducted to establish to 			Yes Date Yes Number Yes Oort)		No No No
M.	In case of Maternity: I. expected date	of Delivery			(DD/MM/Y'Y	YY)	

DETAILS OF PATIENT ADMITTED

A.	Date of admission :	(DD/MM/YYYY)					
В.	Time of admission:	(HH:MM)					
C.	Is this emergency/planned hospitalization event	Emergency Planned					
D.	Mandatory Past History of any chronic illness I. Diabetes ii. Heart disease iii. Hypertion iv. Osteoarthritis v. Asthma/COPD/Bronchitis vi. Cancer vii. Alcohol/Drug abuse viii. Any HIV or STD Related ailment ix. Rheumatoid Arthritis x. Cerebrovascular Accident(Stroke) xi. Liver disease xii. Kidney disease xiii. Any other ailment, give details	if yes (Since month/year)					
E.	Expected number of Days/Stay in hospital :	Days					
F.	Level / Grade of Surgery:						
G.	Days in ICU:	Days					
Н.	Room Type:						
I.	Per day room rent + nursing and service charges +patients diet:						
J.	Expected cost of investigation + diagnostic:						
K.	ICU Charges:						
L.	OT Charges						
M.	Professional fees Surgeon + Anesthetist fees + consultation Charges:						
N.	Medicines + Consumable + Cost of Implants (if applicable please specify):						
Ο.	Other hospital expenses if any:						
P.	All-inclusive package charges if any applicable :						
Q.	Sum Total expected cost of hospitalization :						

DECLARATION

(Please read very carefully)

A.	Name of the treating doctor	:	
В.	Qualification	:	
C.	Registration number with state code	:	
	Hospital Seal		Patient/Insured Name and Sign

(Must include Hospital Id)

DECLARATION BY THE PATIENT / REPRESENTATIVE

- a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
- d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A.
- e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA
- h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

Authorization to Star health and allied Insurance Co. Ltd

1 a	m admitted in your Hospital		from
me	dical information / records from y	ou or from the Me	Ltd. and its representatives, who is my Health Insurer to seek any edical Practitioners who have attended on me in connection with the k any such information / records / indoor case papers, kindly oblige.
a)	Patient's / Insured's Name	3	
b)	Contact number	4 -	
c)	e-mail Id		
d)	Patient's / Insured's Signature	<u> </u>	=======================================
Da	le :		Time:

HOSPITAL DECLARATION

- a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / insurance Company within 7 days of the patient's discharge.
- c. we agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
- d. The patient declaration has been signed by the patient or by his representative in our presence
- We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- f. We will abide by the terms and conditions agreed in the MOU
- g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).
- h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).

1. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the

authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal

Doctor's Signature

List:



Proposer Name

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Middle Name

CIN: L66010TN2005PLC056649 Email: support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

Customer AML - KYC Addendum Form

First Name

Proposer's Recent Photograph with clear background

Last Name

	1					
Permanent Address [Same as Proof of Address]	City / Town / Village	State	 Pin (Code		
	Please Tick if current address is same as permanent address					
Current Address	City / Town / Village					
	District	State	Pin (Pin Code		
Gender	Male Female	Transgender				
Please attach any one proof in support of ID and Address	☐ Voter ID ☐ Driving License Exp Dt.:	Aadhar Card Passport Exp Dt.:	☐ NREGA Job Card	Any Govt.Notified Document		
PAN Number or Form 60 Furnished*						
Father / Spouse Name	First Name	Middle Name		Last Name		
Mother Name	First Name	Middle Name		Last Name		
Income Source	Salary Business	Others please specify				
Are you (Proposer) or any of	Yes No					
the insured person is a PEP						
(Politically Exposed Person) or related to PEP**						
[If Yes, Please provide details]						
**Politically Exposed Persons (PEPs) are indiv	·	rominent public functions in a foreign country, ex				
politicians, senior government / judicial / military officials, senior executives of state owned corporations, important political party officials, etc., including their family members and close relatives The Pan card or Form 60 copy is mandatory						

Declaration: 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.

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In care of any of the above information found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.