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, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.
Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522
CIN : U66010TN2005PLC056649 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 : STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital:

SHALOM MAX HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600 024

I.Address

ii.Rohini ID

iii.e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : Murthy raj

B. Gender: [✓] Male [ ] Female [ ] Third Gender

C. Age: 43 (Years) / (Month)

D. Date of Birth: (DD/MM/YYYY)

E. Contact number: 9094031994

F. Contact number of attending Relative: -

G. Insured Card ID number: CB0000531530001b219815

H. Policy number/Name of Corporate:

I. Employee ID :

J. Currently do you have any other mediclaim / health insurance: Yes [ ] No [✓]

i.Company Name:

ii.Give Details:

K. Do you have a family Physician: Yes [ ] No [✓]

L. Name of the family Physician: NA

M. Contact number, if any:

N. Current Address of Insured Patient:

O . Occupation of Insured Patient:

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: Dr. T. Sulochappan

B. Contact number:: _____

C. Nature of illness/Disease with presenting complaint : C/O, High grade fever x 5 days assoc vomiting, C/O, cough & Expectoration (+)

D. Relevant Critical Findings: _____

E. Duration of the present ailment 5 Days

iv. Date of First consultation 27/01/24 (DD/MM/Y'YYY) C/O, Headache (+) giddiness (+)

v. Past history of present ailment, if an Nil

F. Provisional diagnosis:

ICD I0 code AFI & Evaluation.

G. Proposed line of treatment:

I.	Medical Management	(✓)
II.	Surgical Management	( )
III.	Intensive care	( )
IV.	Investigation	( )
V.	Non-allopathic treatment	( )

H. If investigation and/or Medical Management, provide details: Enclosed

i. Route of Drug Administration I.V/oral

I. If surgical, name of surgery:

i. ICD I0 PCS code Nil

J. If other treatment, provide details: Nil

K. How did injury occur: _____

L. In case of accident:

i.	Is it RTA	Yes ☐	No ☐	NA
ii.	Date of injury	Yes ☐	No ☐	
iii.	Report to Police	Yes ☐	No ☐	
iv.	FIR NO	Yes ☐	No ☐	
v.	Injury/Disease caused due to substance			
vi.	abuse/alcohol consumption	Yes ☐	No ☐	
vii.	Test conducted to establish this (if yes, attach report)	☐	No ☐	

M. In case of Maternity:

I. expected date of Delivery _____ (DD/MM/Y'YYY)

DETAILS OF PATIENT ADMITTED

A. Date of admission : (DD/MM/YYYY) 27/01/2024

B. Time of admission: (HH:MM) _____

C. Is this emergency/planned hospitalization event Emergency ☑ Planned ☐

D. Mandatory Past History of any chronic illness if yes (Since month/year)

i. Diabetes
ii. Heart disease
iii. Osteoarthritis
iv. Asthma/COPD/Bronchitis
v. Cancer
vi. Alcohol/Drug abuse — Nil
vii. Any HIV or STD Related ailment
viii. Rheumatoid Arthritis
ix. Cerebrovascular Accident(Stroke)
I. Liver disease
xi. Kidney disease
xii. Any other ailment,give details

E. Expected number of Days/Stay in hospital : 4-5 Days

F. Level / Grade of Surgery: _____

G. Days in ICU: _____ Days

H. Room Type: Twin Sharing

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): _____

O. Other hospital expenses if any: _____

P. All-inclusive package charges if any applicable : _____

Q. Sum Total expected cost of hospitalization : ₹ 85000/-

DECLARATION

(Please read very carefully)

A. Name of the treating doctor : Dr Palaniappan

B. Qualification : _____

C. Registration number with state code : _____

MEDWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
United India Colony,
Kodambakkam, Chennai-600 024

Hospital Seal
(Must include Hospital Id)

Patient/Insured Name and Sign

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

I am admitted in your Hospital _____ from _____

I hereby authorize Star health and allied Insurance Co. Ltd. and its representatives, who is my Health Insurer to seek any medical information / records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information / records / indoor case papers, kindly oblige.

a) Patient's / Insured's Name : Nomraj

b) Contact number : _____

c) e-mail Id : _____

d) Patient's / Insured's Signature : _____

Date : _____ 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

e. 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 liom 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).

I. 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.

MEDWAY HOSPITALS
No. 2, Old No. 26, 1st Main Road,
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Kodambakkam, Chennai-600 024

Hospital Seal

Doctor's Signature

Date :_____Time:_____

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Phone : 044 - 28288800 Telefax : 044 - 28260062 Website :
IRDA Registration No : 129 ; Corporate Identity Number : L66010TN2005PLC056649

www.starhealth.in

Certificate of Insurance

STAR GROUP HEALTH INSURANCE POLICY FOR BANK CUSTOMERS

Unique id : SHAHLGP21290V022021

Master Policy No	P/900000/01/2023/000125
Certificate No.	P/111116/01/2024/000101
Account Number	7523010000057
Previous Certificate No.	P/111116/01/2023/000162
Name and Address of the Account Holder cum Insured Person E.MUTHU RAJ OLD NO:14,NEW NO:27,THOLKAPPIYAR STREET,M.G.R NAGAR,K.K.NAGAR,CHENNAI Chennai-600078 Tamil Nadu	
Contact No :	9094031994
Email ID :	mrengineers.hvac@gmail.com
Fulfiller Code :	SO111116
Name and Address of the Proposer	M/S.BANK OF BARODA Baroda Corporate Centre, Plot No. C-26, Block G, Bandra Kurla Complex, Bandra (East) Mumbai-400051 Maharashtra

Details of Insured Person(s)

Sl.No	Name of the Insured Person	Gender	Date of Birth	Relation with the Member	Sum Insured	Premium	ID Card No
1	E.MUTHU RAJ	M	31/10/1980	Self	300000	6020	CB000005315 300016219815
Pre- existing disease: NIL							

Details of Dependent

Sl.No	Name of the Insured Person	Gender	Date of Birth	Relation with the Member	ID Card No
1	M.SATHIYA PRIYA	F	12/09/1986	SPOUSE	CB0000053153000016219816
Pre- existing disease: NIL					
2	M.NIRANJAN RAJ	M	07/09/2008	DEPENDANT CHILD	CB0000053153000016219817
Pre- existing disease: NIL					
3	M.DIYA SHREE	F	22/05/2014	DEPENDANT CHILD	CB0000053153000016219818
Pre- existing disease: NIL					

Issue Office Address:
No.36
Kalpalathika Towers 1st Floor
Dr. Ambedkar Road, Kodambakkam, Chennai-600024
CHENNAI
Date: 29/01/2024

For Star Health and Allied Insurance Co., Ltd.,

Authorised Signatory.

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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Phone : 044 - 28288800 Telefax : 044 - 28260062 Website :
IRDA Registration No : 129 ; Corporate Identity Number : L66010TN2005PLC056649
www.starhealth.in

Period of Insurance	From : 13/06/2023 To : 12/06/2024	
Scheme Description :	2A+2C	
Total Sum Insured (Rs.)	Rs.300000 /-	
Premium Details	Premium	Rs. 6020 /-
	GST	Rs. 1084 /-
	Total	Rs. 7104 /-

Nominee Details

Sl.No	Name of the Nominee	Gender	Age of the Nominee	Relation with the Member	Appointee (if Minor)	Appointee Age	Appointee Relation
1	M.SATHIYA PRIYA	F	36	SPOUSE			

Coverage Details

Eligible Room Category

Sum Insured Rs	Limit Rs
2,00,000/-	Up to 2,000/- per day
3,00,000/- & 4,00,000/-	Up to 5,000/- per day
5,00,000/ - to 25,00,000/-	Single Standard A/C Room

Expenses relating to hospitalization will be considered in proportion to the eligible room category stated in the policy or actual whichever is less.

b. **Cataract:** Expenses incurred on treatment of Cataract is subject to the limit as per the following table

Sum Insured Rs	Limit per eye Rs.	Limit per policy period Rs.
2,00,000/-	Up to 12,000/-per eye, per policy period	
3,00,000/-	Up to 25,000/-	Up to 35,000/-
4,00,000/-	Up to 30,000/-	Up to 45,000/-
5,00,000/- & 7,00,000/-	Up to 40,000/-	Up to 60,000/-
10,00,000/- to 25,00,000/-	Up to 50,000/-	Up to 75,000/-

a.Pre hospitalization expenses up to 60 days prior to date of admission
b.Post hospitalization expenses up to 90 days after date of discharge
c.Road Ambulance expenses up to Rs.750 per hospitalization & maximum of Rs.1500 during entire period of insurance

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CHENNAI
Date: 29/01/2024

For Star Health and Allied Insurance Co., Ltd.,

Authorised Signatory.

d.Automatic Restoration of Sum Insured: There shall be automatic restoration of the **Sum Insured** immediately upon exhaustion of the Sum Insured, which has been defined, during the policy period upto 25% of the Sum Insured. Restoration will operate only after the exhaustion of the sum insured.
It is made clear that such restored Sum Insured can be utilized only for illness / disease unrelated to the illness / diseases for which claim/s was / were made. The unutilized restored sum insured cannot be carried forward.
Note: Automatic Restoration of Basic Sum Insured is available only for sum insured options of Rs.3,00,000/- and above.
Not applicable for Sum Insured of Rs.2,00,000/-.
e.All day care treatment covered
f.Organ Donor Expenses for organ transplantation where the insured person is the recipient are payable provided the claim for transplantation is payable and subject to the availability of the sum insured. Donor screening expenses and post-donation complications of the donor are not payable. This cover is subject to a limit of 10% of the sum insured or Rs.1 lakh whichever is less.
g.AYUSH Treatment: In-patient hospitalization expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines in a Government Hospital or in any institute recognized by the government and / or accredited by the Quality Council of India / National Accreditation Board on Health is payable up to the limits given below:
Note: Payment under this benefit forms part of the sum insured.

Sum Insured Rs	Limit per policy period Rs.
Up to 4,00,000/-	Up to 10,000/-
5,00,000/- to 15,00,000/-	Up to 15,000/-
20,00,000/- and 25,00,000/	Up to 20,000/-

Cost of Health Checkup: Expenses incurred towards cost of health check-up up to the limits mentioned in the table given below for every claim free year provided the health checkup is done at network hospitals and the policy is in force. Payment under this benefit does not form part of the sum insured. If a claim is made by any of the insured persons, the health check up benefits will not be available under the policy for the other covered members of the family of that insured person who has made a claim.

Note : Payment of expenses towards cost of health check up will not prejudice the company's right to deal with a claim in case of non disclosure of material fact and / or Pre-Existing Diseases in terms of the policy.

Sum Insured (Rs.)	Limit Per Policy Period (Rs.)
2,00,000/-	Not Available
3,00,000/-	Up to 750/-
4,00,000/-	Up to 1,000/-
5,00,000/-	Up to 1,500/-
7,00,000/-	Up to 1,750/-
10,00,000/-	Up to 2,000/-
15,00,000/-	Up to 2,500/-
20,00,000/-	Up to 3,000/-
25,00,000/-	Up to 3,500/-

Air Ambulance charges up to 10% of the sum insured, provided that
1. It is for life threatening emergency health condition/s of the insured person which requires immediate and rapid ambulance transportation to the hospital/medical centre that ground transportation cannot provide.
2. Necessary medical treatment not being available at the location where the Insured Person is situated at the time of

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CHENNAI
Date: 29/01/2024

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Permanent Exclusion Details Of Insured Person

Insured Name	ID Card	Permanent Exclusion Disease

Permanent Exclusion Details Of Dependent

Insured Name	ID Card	Permanent Exclusion Disease

Star Health and Allied Insurance Company Limited

Customer Identity Card

Policy No. : P/900000/01/2023/000125 **Valid From:** 13/06/2023
Certificate No: P/111116/01/2024/000101

S.No.	Name	Age(Yrs)	Relationship	Sum Insured	ID Card No
1	E.MUTHU RAJ	42	Self	300000	CB000005315300016 219815

IRDAI Regn. No:129

Emergency Help Line No. 1800 425 2255 or 1800 102 4477
e-mail : support@starhealth.in Website : www.starhealth.in

Please quote the Customer Id No. for assistance

- This ID Card is invalid, if the insurance cover is not in force.
- Immediate intimation to 'Star' through above Tel Nos. is a must in case of Hospitalisation.

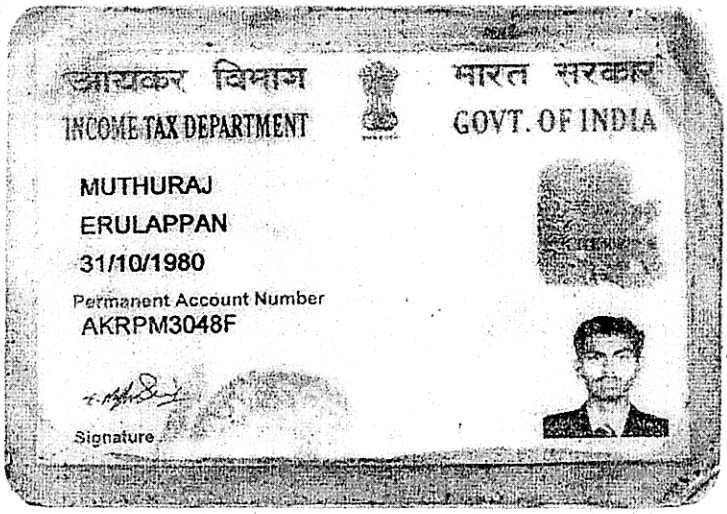
At the time of hospitalization, kindly submit any **Government approved photo ID Card.**

Personal and Caring

Issue Office Address:
No.36
Kalpalathika Towers 1st Floor
Dr. Ambedkar Road, Kodambakkam, Chennai-600024
CHENNAI
Date: 29/01/2024

For Star Health and Allied Insurance Co., Ltd.,

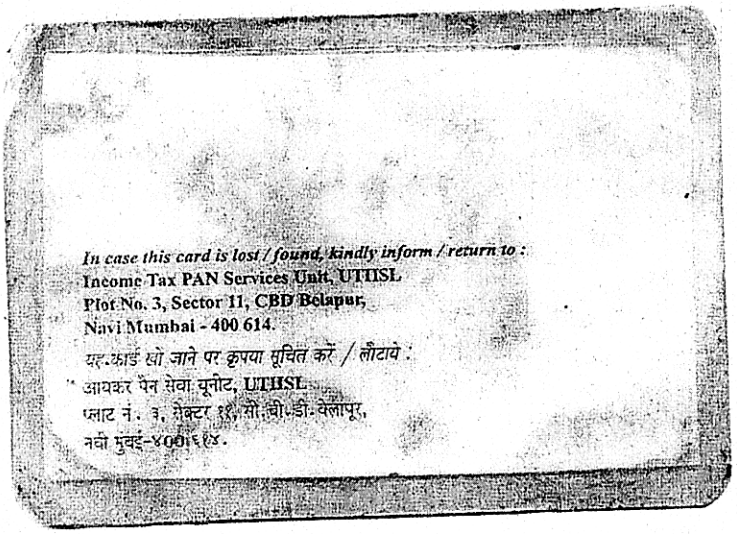
Authorised Signatory.



आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA

MUTHURAJ
ERULAPPAN
31/10/1980
Permanent Account Number
AKRPM3048F

Signature



In case this card is lost / found, kindly inform / return to :
Income Tax PAN Services Unit, UTIISL
Plot No. 3, Sector 11, CBD Belapur,
Navi Mumbai - 400 614.
यह कार्ड खो जाने पर कृपया सूचित करें / लौटायें :
आयकर पैन सेवा यूनीट, **UTIISL**
प्लाट नं. ३, सेक्टर ११, सी.बी.डी. बेलापूर,
नवी मुंबई-४००६१४.

இந்திய அரசாங்கம்

Unique Identification Authority of India

Government of India

பதிவு அடையாளம் / Enrolment No.: [illegible]

To

இ. முத்துராஜ்

E Muthuraj

S/O: Elumalai

C NO 14 N NO [illegible] STREET

MGR NAGAR

Kalaignar Karunanidhi Nagar

Kalaignar Karunanidhi Nagar

Chennai, Chennai

Tamil Nadu - 600078

[illegible]

MP9729660[illegible]

உங்கள் ஆதார் எண் / Your Aadhaar No.:

8621 7109 8539

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

இந்திய அரசாங்கம்

Government of India

இ. முத்துராஜ்

E Muthuraj

பிறந்த தேதி / DOB: [illegible]

ஆண் / Male

8621 7109 8539

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

MH/PRINT /0064/ N

Room No.	Mr.MUTHUR J.E 43/Male/MMH202473350 27/01/2024/II 2024000205 Dr.T.PALANIAPPAN	**Medway Hospitals®** *The way to better health*	**I P INSTRUCTION AND MONITORING CHART**
Dr. Name			
Name			

Date		27/1/24						28/1/24						29/1/24						30/1						31/1																	
PR	BP	Day / Night						Day / Night						Day / Night						Day / Night						Day / Night						Day / Night						Day / Night					
		12	4	8	12	4	8	8	6	8	12	4	6	8	6	8	12	4	6	8	6	8	12	4	6	8	6	8	12	4	6	8										
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Inv																																										
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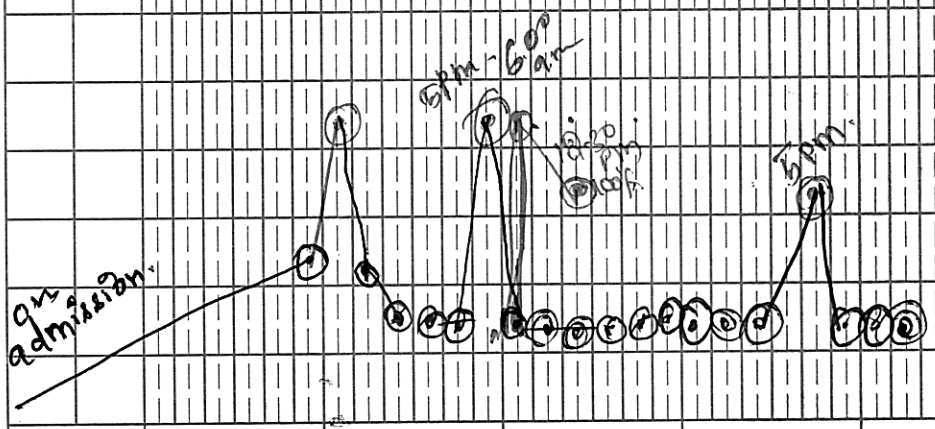

Medway Hospitals®
The way to better health

DRUG CHART

MH/ PRINT / 0042 / ...

Name of the Patient : Mr Muthuraj E. Age 43 Sex M Bed No. 401 - A.

Clinical Diagnosis : Acute febrile illness IP No. 0205 Ht - Wt -

Primary Consultant Name : Dr. T. Palaniappan PID No.

Name of the Medicine	Dose	Route	Frequency	27/1	28/1	29/1	30/1	31/1		
Inj CEFOLS	1.5gm	IV	1-0-1	9pm	9 am I stop					
Inj PARA	1gm	IV	1-1-1	ER	7 am (2pm) 9pm	6.30 am 12.30 9pm	9 am 6pm	8 am		
Inj Pan	40mg	IV	1-0-1	ER	9 am 9pm	8 am 9pm	7 am 9pm	7 am		
Inj Emecet	2cc	IV	1-0-1	ER	7am 9pm	9 am 9pm	7 am 9pm	7 am		
C. Doxy	100mg	PO	1-0-1		9 am (D1) 9pm	9 am (D1) 9pm	9 am (D2) 9pm	8 am (D2)		
Inj. MONOCEF	1gm	IV	1-0-1		9pm	9 am 9pm	9 am (D2) 9pm	8 am (D3)		
T. UDILIV	300 mg	P.O	1-0-1		9pm	9 am 9pm	9 am 9pm	8 am		
T. NUSAM	400 mg	P.O	1-0-1		9pm	9 am 9pm	9 am 9pm	8 am		

Administered by (Nurse Signature) :

Verified by (DMO Signature) : 183161

Nurse Signature : A2649	DMO Signature : 183161	Primary Consultant Signature : 183161
Nurse Name : A. Archana	DMO Name : Peer Mohamed Farhan	Primary Consultant Name : Dr. T. Palaniappan
Date & Time : 27/1/24 9.00 pm	Date & Time : 27/1/24 & 9.00 pm	Date & Time : 27/1/24 & 9.00 pm
		Reg No. :

Allergic to .... Adverse Reaction, if any ....

Medway Hospitals
The way to better health

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS
28/1	3.pm.	IM. Avil	1cc	IO	DR.S.P	

SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS