STAR HEALTH AND ALLIED INSURANCE CO. LTD.

MEDICAL INSURANCE CLAIM FORM

Policy No.:	POL-IN-987654
Claim No.:	STAR_HEALTH_session_
Date of Claim:	05/09/2025

PATIENT DETAILS

Name of Insured:	
Date of Birth:	N/A
Age:	N/A
Gender:	N/A
Address:	N/A
Contact No:	N/A
Email ID:	N/A

HOSPITAL DETAILS

Name of Hospital:	Springfield General Hospital
Hospital Address:	N/A
Doctor Name:	
Date of Admission:	
Date of Discharge:	
Nature of Illness:	
Total Bill Amount:	■169350.0

BANK DETAILS FOR REIMBURSEMENT

Account Holder Name:	
Account Number:	
IFSC Code:	

Bank Name:	
Branch:	N/A

DECLARATION

I hereby declare that the information provided above is true and correct to the best of my knowledge. I understand that any false information may result in rejection of my claim.

Signature of Insured: _____ Date: _____

Name: Policy No: POL-IN-987654