HEMADRI CEMENTS LIMITED

(In Voluntary Liquidation w.e.f. 14.07.2025)
Liquidator Office Address : **S. Rajendran,** 2nd Floor, Hari Krupa,
71/1, McNicholas Road (Off. Poonamalle High Road), Chetpet, Chennai - 600 031.
Phone : 044 - 2836 1636 E-Mail :- vlphemadricements@gmail.com
CIN : L26942AP1981PLC002995 website :- www.hemadricements.com

Ref.: SR/IP/HCL/177/2026-27
Date: 19th Nov 2026

To,
BSE Limited
Phiroze Jeejeebhoy Towers,
Dalal Street,
Mumbai – 400001

Dear Sir/Madam,

Sub: Newspaper Advertisement pertaining to the distribution of proceeds to the shareholders of the Company
Ref.: Published in Times of India – All India Edition (English) on 19.11.2026
Scrip Code: 502133 ISIN: INE07BK01011

In terms of Regulations 30(1) of the Securities and Exchange Board of India (Listing Obligations & Disclosures Requirements) Regulations, 2015, it is hereby once again informed that the Liquidator of Hemadri Cements Limited ('Company') has undertaken the distributions to the shareholders of the Company.

As part of this process, the Liquidator had made a newspaper advertisement in Times of India – All India Edition, English on 19th Nov 2026, requesting the shareholders who hold the shares in physical form to update/notify any changes in their postal address, email, bank details etc. to the RTA of the Company enabling them to release the respective shareholders' payout.

[Website: https://cambridge.cameoindia.com/module/Downloadable_Formats.aspx]

If no communication is received within 7 working days from issue of this notice, the Liquidator will proceed with issuing Cheque at Par/Warrant to the shareholders with the last available address as per RTA records.

Thanking You
Regards,

19/11/26



S. Rajendran
Liquidator
In the matter of Hemadri Cements Limited – In Voluntary Liquidation
IBBI Regn. No. IBBI/IPA-002/IP-N00098/2017-18/10241
Authorisation for Assignment valid upto 31st December 2026

Encl: Copy of advertisement in Times of India newspaper dated 19.11.2026

Hiking Govt Health Insurance To ₹25 Lakh Means Little Without Access To Cashless Treatment

Why a higher health cover may not mean better care

T Sundararaman



Tamil Nadu is now offering families ₹25 lakh in health insurance. The harder task is ensuring that a patient who carries the card does not leave the hospital without treatment or with a substantial bill for care promised free.

Almost no claim under the Chief minister's comprehensive health insurance scheme exceeds the existing ₹5 lakh limit. Reimbursement rates are below market prices, and some expensive treatments, including liver, lung and heart transplants or cochlear implants, draw on a separate corpus. Raising the ceiling addresses a limit that almost no claim reaches. It does not address the barriers that prevent patients from receiving cashless care.

An analysis of the National Sample Survey's 80th round, conducted in 2025, shows that in Tamil Nadu's public hospitals, patients covered by publicly funded insurance spent an average of ₹4,077 out of pocket, against ₹4,509 among the uninsured — a reduction of barely 10%. In private hospitals, including for-profit and NGO/trust facilities, insured patients spent ₹78,883 on average, against ₹68,096 among the uninsured. That is about 16% more, rather than the cashless care promised. Nationally, spending by the two groups in private hospitals was nearly equal.

The govt now plans to launch the Chief minister's elderly health insurance scheme, a programme that will provide free, cashless medical treatment to nearly 38 lakh residents aged 70 and above, with no income ceiling for eligibility. But it's value depends on whether patients obtain the benefits they are promised.

The first barrier appears before treatment. Some eligible patients cannot obtain state health insurance cards because they lack documents or cannot navigate registration. Poor households, daily wagers and migrants are particularly vulnerable.

Public hospitals should provide temporary registration, deliver treatment and complete documentation afterwards. Instead, patients are often asked to obtain cards before procedures such as angioplasty or bypass surgery. Administrative requirements should determine how hospitals receive payment, not whether patients receive care.

A card also offers little help when patients do not know which services it covers or which hospital can provide them. An empanelled hospital may lack the specialist or equipment. Patients discover these gaps only after travelling between hospitals or accept the first provider's terms because they cannot afford further delay.

Primary care providers should guide referrals. Help-desks and helplines should identify hospitals with available beds and the capacity to treat the patient. The scheme pays for helpdesks and Arogya Mitras to provide such guidance. Responsibility must remain with providers, rather than fall on sick people trying to interpret a benefits package.

Another problem is that while private hospitals accept and enrol for the scheme, they often decline cashless treatment. So, patients end up skipping treatment or paying from their own pockets. Weak enforcement by the govt leaves a gap between advertised access and available care. While hospitals argue that reimbursement rates cannot sustain services, government fears enforcement will drive hospitals out of the scheme.

Public hospitals face different pressures. Overcrowding and inadequate budgets force them to ration services through waiting lists, restricted hours and referrals. Judging performance by insurance revenue adds an incentive to prioritise reimbursable patients and procedures. Instructions against denying care compete with financial targets. Reform must address those incentives.

Insurance payments have helped public hospitals establish dialysis, cardiac procedures, joint replacements, transplants and advanced cancer care. They also provide flexible funds. Removing this funding without an alternative would damage capacity. The answer is to change how the money flows. Instead of requiring a separate claim for each episode, the state could calculate the value of a hospital's previous year's inpatient services at agreed reimbursement rates, add 10% for rising costs and anticipated growth, and release a top-up grant in two instalments. This would retain funding while reducing paperwork and procedural rejections. Independent agencies could audit hospital records rather than scrutinise every claim before payment.

Similarly, rural hospitals should not receive less simply because of their location. Equipment, maintenance and specialist staffing do not automatically cost less because they are in hospitals outside cities.

Allocations would reflect workload: a crowded hospital treating complex cases should not receive the same amount as a comparable institution with empty beds. The details need careful design, but resources should follow the work hospitals perform. Revisions must be followed by transparent costing and regular adjustments. Hospitals must distinguish an actual loss from revenue they might have earned from a full-paying patient. Treating an additional patient in unused capacity does not cost the same as establishing a new service. Private participation remains necessary. Public capacity cannot meet demand for services such as dialysis, and expanding specialist care takes time. Public-spirited private providers also use the scheme to reach poorer patients.

Insurance should purchase that additional capacity, not divert services public hospitals can provide. Not-for-profit providers should receive preference. The principle should be public hospitals first, backed by timely, cashless referrals when they cannot deliver treatment. For patients awaiting cancer treatment or cardiac procedures, delay can defeat the purpose of coverage. Neither retaining the present system nor abandoning publicly funded insurance offers a satisfactory answer. Public hospitals need additional financing, while private providers can fill capacity gaps. Someone must remain accountable for getting the patient treated.

The test of TN's scheme is whether that a person receives treatment needed, in time, without being made to pay for it.

— As told to Pushpa Narayan

(T Sundararaman is a public health expert who was appointed in the high level committee to look into the functioning of the chief minister's health insurance scheme)

Email your feedback with name and address to southpole.toi@timesofindia.com

TALK BACK

'A hero's silence, a party's shame', (Nov 16) by Arun Ram on six months of TVK-led govt

A voter's responsibility

The article highlights how TVK, which came to power promising clean politics, has seen several functionaries face serious allegations within six months, ranging from sexual harassment and assault to bribery, narcotics and other criminal activities. The author presents a compelling month-wise chronology of incidents from June to Oct. I appreciate the journalist's efforts to bring these developments to public attention. The question of whether Vijay is reluctant to act against the MLAs for fear of weakening his party's assembly strength is pertinent. His continued silence raises questions about accountability.

Manicklal Chakraborty, Chennai

Good job, media

Your article offers an honest assessment of Vijay's inaction. It is a wake-up call, and he should read it dispassionately and take corrective action without delay. Congratulations to you and TOI for reminding people that the media is watching and is not a passive spectator. Unfortunately, some in the media and political circles choose to turn a blind eye to wrongdoing for personal or financial gains. It is heartening to see journalism uphold its responsibility and hold those in power accountable.

B M Rajasekharan, Chennai

'In Nilgiris, an uphill battle against sickle cell disease' (Oct 16) by Shantha Thiagarajan on how the blood disorder affects tribal communities

Disturbing prevalence

As a retired professor and researcher in Irula tribal genetics from Madurai, I was surprised to learn that India's first reported case of sickle cell disease was from the Nilgiris in 1954, although central India remains a hotspot. The Union govt's national sickle cell anaemia elimination mission is a commendable initiative. The reported 10% prevalence of sickle cell trait among both tribal and non-tribal populations is alarming. The govt and stakeholders must promote research in the area. NGOs NAWA and Ashwini deserve appreciation for their commendable work.



K Balakrishnan, Chennai

'Walkers, for your own safety, LED the way' (Oct 19) by G Ananthakrishnan on pedestrian safety

Walking hazard

Your article was informative and thought-provoking. It reminded me of our experience when we lived in Choolaimedu and Metha Nagar three years ago. Walking on the pavements was almost impossible because traders had extended their business spaces by encroaching on them. While two-wheelers could navigate the roads, pedestrians were forced to walk along the edges of roads barely 24ft wide. This problem is not confined to Chennai but is prevalent in almost every small town in Tamil Nadu. Traders encroach on pavements and public spaces, while civic officials, councillors and the police turn a blind eye. Even residents seem indifferent. Pedestrians also have to contend with stray cattle. Even in smart city areas, where wider pavements have been created, vendors occupy them, as seen in Pondy Bazaar. This problem will persist unless strict laws are enacted and enforced. I recall that during the Emergency (1975-77), roads were remarkably clean, pavements were free of encroachments and unnecessary parking was strictly controlled. As a second-year college student, I once had my bicycle taken away by the police when I stopped to buy a notebook! It makes one wonder why the authorities cannot enforce pedestrian-friendly rules.



G N Annadurai, Chennai

CLARIFICATION: In the article 'What ails Tamil Nadu's jails?' (Oct 29) by Shanmughamsundaram J, Beulah Immanuel, deputy director of APCA, was quoted as describing the undertrial review committee (UTRC) as "inefficient". She has clarified that the UTRC is "an effective institutional mechanism for reducing the undertrial population in prisons".

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Sessions include hands on practice
Course Timing- Time-7.30 pm to 8.30 pm
Course Duration 10 days
ऑनलाइन ONLINE
Course Date- 24 Nov to 03 Dec.2026
Email ID: trg@igtr-indore.com website: igtr-indore.com Phone: (0731) 4210700/709
Contents : Cyber crime & terrorism, Type of attacks, Goal of Security & computer Forensic, Social Media, Mobile Hacking, Cyber Hacking, Digital Forensic, Data Recovery.
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SOUTHERN RAILWAY
Construction Organisation
Ernakulam Jn
TENDER NOTICE No. 36-CE-CN-ERS-2026-OT,
DATED: 16.11.2026
Name of Work: Patch doubling of track between Shoranur and Vallathol Nagar (SRR-VTK) Section-re-construction of ROB No. 7A etc., Vallathol Nagar station; Tender Value : ₹ 7367.98 Lakhs; Bid Security : ₹ 1,47,36,000/- ; Completion Period : 24 Months.
Date and time of tender closing: 11.12.2026 at 15.00 Hrs.
Complete details and tender document will be available at https://www.ireps.gov.in
Chief Engineer / Construction, Ernakulam Jn
(For and on behalf of President of India)

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HEMADRI CEMENTS LIMITED
(IN VOLUNTARY LIQUIDATION)
(CIN: L26942AP1981PLC002995)
ATTENTION OF SHAREHOLDERS –
DISTRIBUTION OF PROCEEDS TO THE SHAREHOLDER OF THE COMPANY
Notice is hereby given that the Liquidator of the Company has commenced distribution to the Equity Shareholders of the Company of a sum equivalent to the face value (ie., Rs. 10/- per share) of the shares held.
As part of this process, the Liquidator has made payments to the following Equity Shareholders who held the shares in Demat format:

Sl. No.	Payment Mode	No. of records	Total No. of Shares	Total Amount Paid (in Rs.)	Date of Payment
01	NEFT/ RTGS	4712	7,25,296	72,52,960	20th and 21st July 2026
02		1	14,96,899	1,49,68,990	7th Nov 2026
03		2	3,23,533	32,35,330	10th Nov 2026

In this regard, Liquidator has sent a communication to the shareholders holding shares in physical form, through RTA to update/notify changes in address, bank account details etc. However, responses have been received from only a few shareholders.
Further it is once again informed to the shareholders who hold the shares in physical form to update/notify any changes in their postal address, email address, bank account details etc. to the RTA of the Company enabling them to release the respective shareholders' payout.[Website: https://cambridge.cameoindia.com/module/Downloadable_Formats.aspx]
If no communication is received within 7 working days from issue of this notice, the Liquidator will proceed with issuing Cheque at Par/Warrant to the shareholders with the last available address as per RTA records.
Date: 19.11.2026
Place: Chennai
S. Rajendran
Liquidator
In the matter of Hemadri Cements Limited – In Voluntary Liquidation
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Authorisation for Assignment valid upto 31st December 2026
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