



TTK HEALTHCARE SERVICES PRIVATE LIMITED

#7, Jeevan Bhima Nagar Main Road HAL III Stage, Bangalore.

CLAIM FORM

Form No. 9

(Insurance of this Claim Form is not tantamount to acceptance of Liability by the Insurer)

TTK ID No. :

Name & Address of the Insured :
(in whose name policy is issued)

Details of Insured person :
(in respect of whom claim is made)

a) Name & relationship of the Insured
b) Present
completed Age
c) Contact
Address

e) Phone No.
f) Mobile No.
g) E-mail Address

Name of Insurance Company :

Policy No. Serial No. of the Schd/Certificate No.:

AILMENT/DISEASE/INJURY :

Date of Injury sustained of disease / illness first
detected :-Name of the Hospital :

a) Have you been Insured under any Mediclaim
Scheme
earlier (held with us or any other Insurance Co.) If yes
Xerox copies of Previous years' policies **MUST** be
enclosed. :

b) Date of Commencement of very first Insurance for
this
Insured person with continuous Insurance coverage :

Have you preferred any claim for the same **insured under**
under the Mediclaim scheme earlier, if so give details viz
(a) Previous Claim File Ref. No. / Office :
(b) Diagnosis :
(c) Whether settled / Repudiated :
(d) Amount (if settled) : Rs.

Date of Admission Date of Discharge :

Total Amount Claimed : Rs.

If the claim is of Domiciliary Hospitalization please indicate

a) Date of Commencement of the treatment
b) Date of Completion of treatment
c) Name & Address of attending Medical
Practitioner
with Telephone No. & Registration No.

Signature of the Claimant

