

**TTK Healthcare Services Private Limited**  
7 Jeevan Bheema Nagar Main Road, HAL III rd Stage, Bangalore - 560 075  
**CLAIM FORM**

(Issuance 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) Occupation
- d) Contact Address

- e) Phone No
- f) Mobile No
- g) E-Mail Address

Name of the Insurance Company

Policy No.

Serial No. Of the Schd/ Certificate No.:

**AILMENT / DISEASE / INJURY:**

Date of Injury sustained or 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 person with with continous insurance coverage.

Have you preferred any claim for the same insured under the mediclaim scheme earlier, if so, give the following details:

- a) Previous claim file ref.no/office :
- b) Diagnosis :
- c) Whether settled/repudiated :
- d) Amunt (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

Please register PDFcamp on <http://www.verypdf.com/>, thank you.

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

Signature of the claimant

Please register PDFcamp on <http://www.verypdf.com/>, thank you.

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