



WITH YOU ALWAYS

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PLUS**CLAIM FORM**
(Part-A)To be filled in by the insured. The issue of this Form is not to be taken in as admission of liability
Please fill-up this form in CAPITAL LETTERS

DETAILS OF PRIMARY INSURED

(SECTION A)

Policy No: 7000061988

Sl. No. Certification No: Company TPA ID No:

Name (Mr/Mrs/Ms/Dr): PRIYANKA L

First Name Middle Name Surname

Address: 23 SUBRANKA LAYOUT

Landmark: DODDABOMMASANDRA

Area: BEHEND ST PHILOMINASCHOOL

City/Town: BANGGALURU District: BANGGALURU

Pin Code: 560097 State: KARNATAKA

E-Mail: CKR@JUG3.CYREGMAIL.COM

Phone: 9342873663

DETAILS OF INSURANCE HISTORY

(SECTION B)

Currently covered by any other Mediciam/Health Insurance: Yes ☐ No ☒

Date of commencement of first insurance without break: 10/01/2010

If yes, Company Name:

Policy No: Sum Insured (Rs.):

Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☒

Date: 10/01/2010 Diagnosis:

Previously covered by any other Mediciam/Health Insurance: Yes ☐ No ☒

If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED

(SECTION C)

Name (Mr/Mrs/Ms/Dr): PRIYANKA L

First Name Middle Name Surname

Gender: Male ☐ Female ☒ Date of birth: 28/07/1990 Age 32 Years Months

Relationship to Primary Insured: Self ☒ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

Occupation: Service ☒ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)