

Takaful International Company For Takaful Insurance K . S . C . C .

Al Qebalah Area , Fahad Al Salem st., Rakan Tower , Kuwait , P.O. Box 1166 Dasman , 15462

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Dental Claim Form

Please give the following information correctly and completely to enable the company to process your claim promptly :

TO BE COMPLETED BY MEMBER/CLAIMANT

1- Name of the Company/Main Member : Policy Number :

(In whose name policy is issued , Name of the Company in case of Group policy)

2- Details of the Insured Member (In respect of whom claim is made)

Patient's Name :		Membership No. (UHID No.)	
Gender : Male <input type="checkbox"/> Female <input type="checkbox"/>		Employee Number (Policy Group) :	
Date of Birth (D/M/Y)		Other Medical Insurance Coverage – Yes / No (If Yes attach details)	
Telephone Number			
Relationship with the Insured :			
Patient Address :			

3- Medical Provider Name :

4- Medical Provider Address :

5- Date of Treatment :

To Be Completed By Treating Doctor

6- Details of Diseases/Illness contracted or injury suffered :

7- Date of commencement of illness or injury sustained :

Type of Treatment	Amount	Type of Treatment	Amount
Extraction		Filling	
Neurectomy		Gum Treatment	
X-ray		R.C.T	
Cleaning		Scaling	
Bridge		Orthodontics	
Dentures		Crown	
Restoration		Prophylaxis	
Others		Total Claimed Amount	

8- OTHER INVESTIGATIONS DONE:

9- Name of the Doctor :, Tele No. :

Sign of Doctor :, Stamp of Doctor :

Member's/ Hospital's Declaration:

I/We hereby warrant the truth of the foregoing particulars in every respect. I/We agree that if I/We have made or shall make any false or untrue statement, suppression or concealment, my/our right to claim reimbursement of the said expenses shall be absolutely forfeited . I/We hereby authorize Takaful International For Takaful Insurance Co/Wapmed or their authorized representatives to check all the medical records related to treatment from the doctor/hospital.

Member's Signature : Hospital's Signature :

Date : Stamp of Hospital :