

HEALTH INSURANCE CLAIM FORMClaims must be submitted within 90 days of being incurred and original receipts/itemized bills must be attached.



1. TO BE COMPLETED BY EMPLO	YEE / INSURED) :						
Surname: First N			ame:	Date Of Birth: (d/m/yr):				
Address:								
ID No.: Teleph			one Nos.:					
Patient's Name		Relatio	onship: Date Of Birth: (d/m/yr)					
When did symptoms of the ailment first app Have you ever had this ailment before? If y	-							
CAUSE OF CONDITION:			CO-ORDINATION OF BEI	NEFITS:				
Is Patient's Condition Related To: (a) Employment?			Is Patient Covered By Any Other Plans, Which Provide Benefits For This Injury or					
(b) Auto Accident? ☐ Yes ☐ No			Sickness?					
(c) Other Accident? Yes No			If "Yes", give (a) Name Of Insurance Company					
Details:			(b) Insured's Name					
If Yes, State Name of Employer's Insurer:			(c) Name of Group or Company Insured Under					
AUTHORIZATION:			ASSIGNMENT OF INSURANCE BENEFITS:					
I/we hereby certify that the foregoing answ	ers are true and co	rrect to the best of my/	I hereby authorize and direct you to pay to					
our knowledge and hereby authorize all doo	_							
all hospitals or other institutions to furnish		nation (including full	all benefits due to me or my covered dependant (s) as a result of this claim.					
copies of their records) regarding this claim.			I understand that I am financially responsible for charges not covered by the					
Any person who knowingly and with inte			<u>policy.</u> Insured's Signature:					
other person files a statement of claim conta with intent to mislead, conceals informati		·	moure o digitature.					
commits a fraudulent act and is liable to pro		Tact material thereto,	Date:					
		L						
Insured's Signature:		Spouse's Signatur	e: Date:					
2. TO BE COMPLETED BY EMPLOYI	ER / POLICYHO	LDER:						
			Employee Certificate No.: Effective Date:					
Has employee made claim for Workmen's		☐ Yes ☐ No	Is he/she entitled to such benefits?					
Company's Stamp:	Composition	Administrator's Sig						
Company's Stainp:		Administrator 8 Sig	gnature:	Date				
3. TO BE COMPLETED BY OPTICIAL	N/OPHTHALMO	LOGIST/OPTOMETR	Patient's Name: Date Of Birth: (d/m/y	yr)				
Diagnosis	Date of Service d/m/yr		Description of Service		Charge \$			
☐ SINGLE ☐ BI-FOCAL ☐ MULT	∐ I-FOCAL ☐ LEI	 NTICULAR	ACT LENSES SUNGLASSES	TOTAL				
I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED								
	3							
STAMP	SIGN	NATURE OF OPTICIAN	/OPHTHALMOLOGIST/OPTOMET	TRIST DATE				

4. TO BE COMPLETED BY DOCTOR / HEALTH PROVIDER: Patient's Name: Date Of Birth: (d/m/yr)									
Date of Visit Or Service	Diagnos	sis/ICD Code	Visit Fee	Type of Visit	Service Rendered (drugs, injections, tests, supplies)	Cost	Further Services Recommended		
Date of first syn	nptoms:			<u> </u> На	I spatient been previously treated for this c	condition?	☐ Yes ☐ No		
	=				Yes, give date:				
Was patient refe	erred? If "Yes" state name	of referring doctor:			-				
SURGICAL PROCEDURES Date of Surgery:						Fee \$;		
Describe Procedure(s) Performed: Asst. Surgeon									
A CAMPANIAN C	Date Pregnancy Cor	1/7.1/10				ist's Fee \$			
MATERNITY		Date of Delivery or Termination: Obstetrical Fee \$							
	Type of Delivery:				Obstetrica	i ree 🏻 🗈)		
I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED									
STA	MP	SIGNATUR	E OF DOCT	OR/HEA	LTH PROVIDER	Ι	DATE		
5. TO BE COM	MPLETED BY DENTIST	·:			Patient's Name:				
DENTE					Date Of Birth: (d/m/yr)				
DENTIST		TEL No:							
` '	a result of occupational illr a result of auto accident?	ness or injury? Yes			if yes)				
(c) Other accide		☐ Yes							
-631	2015			T OF CE	DVICES (LISE OHADTING SVETEM (CHOWN)			
08	100 m				RVICES (USE CHARTING SYSTEM S	, , , , , , , , , , , , , , , , , , ,			
	Date of Service Tooth (d/m/yr) or Le		face(s)	Description of Service	e	Charge \$			
	- (2)								
Const									
2	· (2)								
48									
- To	000 B	·		•		TOTAL			
00	500kg								
	IC TREATMENT		OWNS		INITIAL DENTURE				
(a) Date of first						_ (a) Is this an initial placement? (b) Date of prior placement:			
(b) Date of last (c) Treatment p						(c) Reason for replacement:			
(d) Monthly trea	med? (d) Were teeth extract	(d) Were teeth extracted for the appliance?							
(e) Total fee:						(e) Date of extraction:			
(f) Indicate teeth replaced by this appliance: I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED.									
STA	MP	SIC	NATURE (OF DENT	IST	I	DATE		