

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 EMPL | OYEE / INSURED: | | | | | | | | |
|--|--|------------------------|--|-------------------------|--------------------------|--|--|--|--|
| Surname: First N | | | ame: | Date Of Birth: (d/m/yr) | Date Of Birth: (d/m/yr): | | | | |
| Address: | | | | | | | | | |
| ID No.: | | Teleph | one Nos.: | | | | | | |
| Patient's Name Relation | | | | | | | | | |
| When did symptoms of the ailment first ap Have you ever had this ailment before? If | | | | | | | | | |
| CAUSE OF CONDITION: | | | CO-ORDINATION OF BENEFITS: | | | | | | |
| Is Patient's Condition Related To: (a) Em | ployment? Yes | ∏No | Is Patient Covered By Any Other Plans, Which Provide Benefits For This Injury or | | | | | | |
| | to Accident? Yes | | Sickness? | | | | | | |
| (c) Oth | ner 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 | vers are true and corre | ect to the best of my/ | I hereby authorize and direct you to pay to | | | | | | |
| our knowledge and hereby authorize all do | octors or other person | s who treated me and | | | | | | | |
| all hospitals or other institutions to furnish | full detailed informa | tion (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 | m | | I understand that I am financially responsible for charges not covered by the | | | | | | |
| | | | policy. | | | | | | |
| Insured's Signature: | | _ | Insured's Signature | × | | | | | |
| | | _ | ъ. | | | | | | |
| Date: | | _ | Date: | | | | | | |
| 2. TO BE COMPLETED BY EMPLOY | ER / POLICYHOL | DER: | | | | | | | |
| Policy Holder: | | Policy No: | Employee Certificate No.: Effective Date: | | | | | | |
| Has employee made claim for Workmen's Compensation? | | ☐ Yes ☐ No | Is he/she entitled to such benefits? | | | | | | |
| Company's Stamp: | | Administrator's Sig | gnature: Date: | | | | | | |
| 13 | | | | | | | | | |
| 3. TO BE COMPLETED BY OPTICIA | AN/OPHTHALMOL | OGIST/OPTOMETR | Patient' | 's Name: | | | | | |
| | | | Date Of | f Birth: (d/m/yr) | | | | | |
| Diagnosis | Diagnosis Date of Service d/m/yr | | Description of Serv | Charge \$ | | | | | |
| | | | | | | | | | |
| | + | | | | + | | | | |
| | | | | | | | | | |
| ☐ SINGLE ☐ BI-FOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES ☐ SUNGLASSES TOTAL | | | | | | | | | |
| I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED | | | | | | | | | |
| STAMP | SIGNATURE OF OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST 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 | | |
| Of Service | | | Tee | VISIT | (urugs, injections, tests, supplies) | | Recommended | | |
| | | | | | | | | | |
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| 5 | | | | | | | | | |
| Date of first symptoms: Has patient been previously treated for this condition? Yes No Date of first consultation for this condition: If Yes, give date: | | | | | | | | | |
| Was patient referred? If "Yes" state name of referring doctor: | | | | | | | | | |
| SURGICAL PROCEDURES Date of Surgery: Surgeon's Fee \$ | | | | | | | | | |
| Describe Procedure(s) Performed: | | | | | Asst. Surgeon's Fee \$ | | | | |
| | | | | | Anaes | thesist's Fee \$ | | | |
| MATERNITY | Date Pregnancy Con | nmenced/LMP: | | | Date of | f Delivery or Tern | nination: | | |
| | Type of Delivery: | | | | Obstet | rical Fee \$ | | | |
| I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED | | | | | | | | | |
| STA | MP | SIGNATURE | OF DOC | ΓOR/HEA | LTH PROVIDER | D | ATE | | |
| 5. TO BE COM | MPLETED BY DENTIST | ': | | | Patient's Name: | | | | |
| DENTIST TEL No: | | | | | | | | | |
| (a) Is treatment a result of occupational illness or injury? | | | | | | | | | |
| | a result of occupational find a result of auto accident? | | ☐ No | | ii yes) | | | | |
| (c) Other accide | nt? | | ☐ No | | | | | | |
| | 773V2 | | LIS | T OF SEI | RVICES (USE CHARTING SYSTI | EM SHOWN) | | | |
| | | Date of Service Tooth | | face(s) | Description of Se | | Charge \$ | | |
| Ø. Ø. | | (d/m/yr) or Lett | | race(s) | Description of Se | rvice | Charge \$ | | |
| Surface 3 S 14 | | | | | | | | | |
| | 15 | | | | | | | | |
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| (F) | (3) | | | | | | | | |
| | 17 (S) | | | | | | | | |
| FF E | LINGUAL K DIO | | | | | | | | |
| | | | ' | , | | | | | |
| | | TOTAL | | | | | | | |
| 0.000 | | | | | | mna c= === | 7.0 | | |
| ORTHODONTI (a) Date of first | C TREATMENT appliance: | | WNS itial placen | | INITIAL DENTURES OR BRIDGES (a) Is this an initial placement? | | | | |
| (b) Date of last a | | | | (b) Date of prior placement: | | | | | |
| (c) Treatment po | | _ | | (c) Reason for replacement: | | | | | |
| (d) Monthly trea | tment fee: | (d) Was root ca | nal treatm | ent perfori | | | | | |
| (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 | SIGN | OF DENT | IST | DATE | | | | |