State Insurance Corporation

Redcliffe Street, P.O. Box 290, St. John's, Antigua, W.I.
Tel: (268) 481-7800 - 7804 Fax: (268) 481-7860 E-Mail: stateins@candw.ag

GROUP MEDICAL INSURANCE

Claim Form

PART I: To be completed by attending physician

Name of Group: **Insured:**

1. Name of Patient:
2. Nature of Illness or Disability
3. Period of Illness or Disability
4. Name of referring physician, if any
5. Is condition due to illness or disability arising out of Patient's employment? Yes ☐ No ☐
6. Is condition due to Pregnancy? Yes ☐ No☐ If yes, give date of delivery / / *(dd/mm/yyyy)*
7. In your opinion when did this injury or illness have its origin? / / *(dd/mm/yyyy)*

8. **DETAILS OF TREATMENT**

TYPE	PARTICULARS	TOTAL FEES
Surgical		
Non-Surgical		
Other		
Office Visit	No. @ $	
Home Visit	No. @ $	
Hospital Visit	No. @ $	
Other		
Services		
	Total	
Office Use Only		
	Total	**$**

STATE INSURANCE CORPORATION
(Office Use Only)

Room	$_____
Hospital Services	$_____
Out Patient	$_____
Surgery	$_____
Anaesthesia	$_____
Diagnostic	$_____
Maternity Benefits	$_____
Prescription Drug	$_____
Consultation	$_____
Other	$_____
Other	$_____
	$_____
	$_____
TOTAL	$_____
Deductible	$_____
Balance	$_____
	$_____
	$_____
TOTAL PAYABLE	$

Signature of Attending Physician …….
Date ……...
Address ……..……..……..….
……...……..…….
Telephone No. ……..

Doctor's Stamp

I hereby request and authorize the attending Physician to disclose, whenever requested to do so, any or all information concerning my medical condition acquired during my examination or treatment.

Signature of Patient ……...
(If patient is a minor, insured sign on their behalf)

NOTE!!! The reverse side of this claim form "MUST" be completed by the Insured

GROUP MEDICAL INSURANCE SCHEME

(Original receipts are required for all incurred expenses)

PART II: **To be fully completed by the Insured**

9. Name of Group Scheme:		
10. Name of Insured:		
11. Address:	Tel Nos.: (H) (W) (C)	
12. Name of covered dependant: *(if patient is a dependant)*		
13. Gender: Male ☐ Female ☐	14. Date of Birth: / / *(dd/mm/yyyy)*	15. Relationship to Insured: Self ☐ Spouse ☐ Son ☐ Daughter ☐
16. Is patient covered by any other Medical Plan? Yes ☐ No ☐	17. If Yes, do you intend to make a claim with any other Insurance Provider? Yes ☐ No ☐	
18. If claim is due to accident, please state: i) Date of accident / / *(dd/mm/yyyy)*		
ii) Place of accident		
iii) Cause of accident		
19. When did this injury or illness have its origin? / / *(dd/mm/yyyy)*		
20. **INSURED'S SIGNATURE.** Signed _____ Date _____		

NOTICE!!!

Claim Form must be completed, signed and returned to the Corporation within ninety (90) days after the date of the loss for which claim is to be made.

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