



State Insurance Corporation

Redcliffe Street, P.O. Box 290, St. John's, Antigua, W.I.

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INDIVIDUAL MEDICAL INSURANCE

Claim Form

PART I: To be completed by attending physician

Name of Insured:

Policy No:

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 <input type="checkbox"/> No <input type="checkbox"/>
6. Is condition due to Pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/> 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	STATE INSURANCE CORPORATION (Office Use Only)	
Surgical				
Non-Surgical			Room	\$ _____
Other			Hospital Services	\$ _____
Office Visit	No. @ \$		Out Patient	\$ _____
Home Visit	No. @ \$		Surgery	\$ _____
Hospital Visit	No. @ \$		Anaesthesia	\$ _____
Other			Diagnostic	\$ _____
Services			Maternity Benefits	\$ _____
			Prescription Drug	\$ _____
			Consultation	\$ _____
	Total		Other	\$ _____
Office Use Only			Other	\$ _____
				\$ _____
			TOTAL	\$ _____
			Deductible	\$ _____
			Balance	\$ _____
				\$ _____
				\$ _____
			TOTAL PAYABLE	\$ _____
				\$ _____
	Total	\$		

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

INDIVIDUAL MEDICAL INSURANCE

(Original receipts are required for all incurred expenses)

PART II: To be completed by the Insured

9. Policy Number:		
10. Name of Insured:		
11. Address:	Tel Nos.: ^(H) ^(W) ^(C)	
12. Name of covered dependant: <i>(if patient is a dependant)</i>		
13. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	14. Date of Birth: / / <i>(dd/mm/yyyy)</i>	15. Relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/>
16. Is patient covered by any other Medical Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	17. If Yes, do you intend to make a claim with any other Insurance Provider? Yes <input type="checkbox"/> No <input type="checkbox"/>	
18. If claim is due to accident, please state:		
i) Date of accident / / <i>(dd/mm/yyyy)</i>		
ii) Place of accident		
iii) Cause of accident		
19. When did this injury or illness have its origin? / / <i>(dd/mm/yyyy)</i>		
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