STATE INSURANCE

COMPANY LIMITED

Redcliffe Street P.O. Box 290 St. John's Antigua. W.I.
(268) 481-7800/1/2/3/4 • info@sicantigua.com • sicantigua.com

CLAIM FORM

GROUP MEDICAL ☐ INDIVIDUAL MEDCIAL ☐ DENTAL ☐ VISION ☐

Name of Group:_____ Insured:_____ Policy No.:_____

PART I: To be completed by attending physician

NAME OF PATIENT:	1. Patient Date of Birth:
2. Address:	3. Referring Doctor, if any:
4. Date of Diagnosis:	5. Date of First symptoms:
6. Type of Treatment:	
7. Nature of Illness or Disability:	Period of Illness or Disability:
8. In your opinion when did this injury or illness have its origin?	
9. Is your condition due to Pregnancy? Yes ☐ No ☐	If #9 yes, give date of delivery:
10. Is your condition a result of Occupational Illness or Injury? Yes ☐ No ☐	If #10 yes, enter brief description and dates:
11. Is your condition a result of Auto Accident? Yes ☐ No ☐	
12. Other Accident? Yes ☐ No ☐	

I hereby authorize and direct you to pay to_____ all benefits accruing to me as a result of this claim to the extent of bills submitted.

Signature of Patient_____

DETAILS OF TREATMENT

TYPE	Particulars	Total Fees	State Insurance Company Limited (Office Use Only)	
Surgical			Room	$
Non-Surgical			Hospital Services	$
Other			Out Patient	$
Office Visit	No. @$		Surgery	$
Home Visit	No. @$		Anesthesia	$
Hospital	No. @$		Diagnostic	$
Other			Maternity Benefits	$
Services			Prescription Drug	$
	Total		Consultation	$
Office Use Only			Other	$
				$
			TOTAL	$
			Deductible	$
			Balance	$
			TOTAL PAYABLE	$

PART II: To be completed by insured

(Claim form must be fully completed and signed in order to avoid a delay in settlement)

13. Name/Address:		14. Tel. No.: (H) (W) (C)	
15. Name of covered dependant: *(If patient is a dependant)*			
16. Gender: Male ☐ Female ☐	17. Date of birth: / /	18. Relationship to Insured: Self ☐ Spouse ☐ Son ☐ Daughter ☐	
19. Is patient covered by other Medical Plan? Yes ☐ No ☐ If so, give name and address of other Insurance Provider:		20. If #19 yes, do you intend to make a claim with any other Insurance Provider? Yes ☐ No ☐	
21. Insured Signature:		Date:	

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.

NOTICE!!!
Original receipts with completed and Signed claim form must be returned to the Company within ninety (90) days

Signature of Patient _____

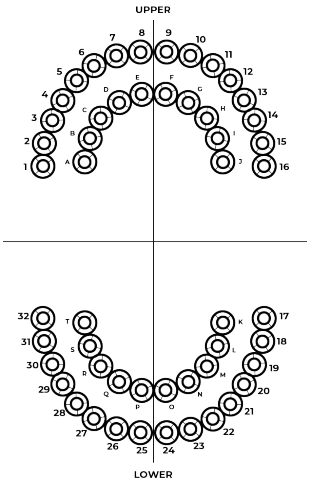
DENTAL SECTION

23. First Visit Date: / /	24. Place of Treatment: Hospital ☐ Office ☐ Other ☐	25. X-Rays or Models Enclosed? Yes ☐ No ☐	How many?
26. If Crown, was tooth badly broken down? Yes ☐ No ☐		27. Is treatment for Othodontics? Yes ☐ No ☐	
28. If Prosthesis, is this initial placement? Yes ☐ No ☐		29. If #28 yes, give date of extractions of teeth? / /	
30. If #28 No, give reason for replacement and date of prior placement. / /			

DENTAL EXAMINATION

List in order from Tooth #1 through Tooth #32 (Use charting system of primary or permanent teeth shown)

Identify Mission Tooth with an "X"
FACIAL



Date Service Performed	Tooth # or Letter	Description of Service *(Including X-Rays, extractions, prophylaxis and examinations)*	Procedure Number	Fees	State Insurance Company Limited OFFICE USE	
					Total	
					Deduct.	
				TOTAL $	Total Payable	

VISION SECTION

31. Diagnosis or Description of Condition:		
32. Did prescription change for: Right eye ☐ Left eye ☐		33. Date Dispensed: / /
34. Is surgery recommended? Yes ☐ No ☐	35. If yes, type of surgery?	36. Date Surgery: / /

37a. If Contact Lenses, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia? Yes ☐ No ☐
Can visual acuity be improved by up to at least 20/70 level by spectacle lenses? Yes ☐ No ☐
Can visual acuity be improved by up to at least 20/70 level by contact lenses? Yes ☐ No ☐
37b. Are these prescriptions sun glasses? Yes ☐ No ☐
Replacement of LOST or DAMAGED GLASSES, Photo-grey/photo-sun? Yes ☐ No ☐

38. Optical supplies furnished by: Address:

VISION EXAMINATION AND TREATMENT

Date Service Performed	Description of Service	Fees		State Insurance Company Limited OFFICE USE	
	Surgical:	$		$	
	Non-Surgical:				
	Office Visit/ Eye Examination:				
	Contact Lenses:				
	Frame:				
	Prescribed Lenses: Single Vision Lenses				
	Bi-Focal Lenses				
	Tri-Focal Lenses				
	Lenticular Lenses				
	Tinting Lenses				
	Hardex/Safety Material				
	Other:				
	TOTAL	$		$	

Signature of Attending Physician _____
Date _____
Address _____
Tele. No. _____

Doctor's Stamp Here