

HEALTH INSURANCE CLAIM FORM

Claims must be submitted within 90 days of being incurred and original receipts/itemized bills must be attached.



1. TO BE COMPLETED BY EMPLOYEE / INSURED:

Surname: _____ First Name: _____ Date Of Birth: (d/m/yr): _____

Address: _____

ID No.: _____ Telephone Nos.: _____

Patient's Name _____ Relationship: _____ Date Of Birth: (d/m/yr) _____

When did symptoms of the ailment first appear? _____

Have you ever had this ailment before? If yes, state when and describe _____

CAUSE OF CONDITION:

Is Patient's Condition Related To: (a) Employment? Yes No
 (b) Auto Accident? Yes No
 (c) Other Accident? Yes No

Details: _____

If Yes, State Name of Employer's Insurer: _____

CO-ORDINATION OF BENEFITS:

Is Patient Covered By Any Other Plans, Which Provide Benefits For This Injury or Sickness? Yes No

If "Yes", give (a) Name Of Insurance Company _____

(b) Insured's Name _____

(c) Name of Group or Company Insured Under _____

AUTHORIZATION:

I/we hereby certify that the foregoing answers are true and correct to the best of my/our knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full detailed information (including full copies of their records) regarding this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or with intent to mislead, conceals information concerning any fact material thereto, commits a fraudulent act and is liable to prosecution.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and direct you to pay to _____

all benefits due to me or my covered dependant (s) as a result of this claim.

I understand that I am financially responsible for charges not covered by the policy.

Insured's Signature: _____

Date: _____

Insured's Signature: _____ Spouse's Signature: _____ Date: _____

2. TO BE COMPLETED BY EMPLOYER / POLICYHOLDER:

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? Yes No

Company's Stamp: _____ Administrator's Signature: _____ Date: _____

3. TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:

Patient's Name: _____

Date Of Birth: (d/m/yr) _____

Diagnosis	Date of Service d/m/yr	Description of Service	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

