



Always there  
when you need us most

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## DENTAL INSURANCE CLAIM FORM

### INSURED MEMBER'S STATEMENT

1. Name of Company/Association: Sun Infrastructure Services
2. Insured Member's Name: B. John Son
3. Date of Birth (DD/MM/YY): 07/09/93 Patient's Relationship to Insured: Father
4. Name of attending Dentist: Rahul
5. When did symptoms of this complaint first appear? A week before
6. Have you ever had this complaint? No  
If "YES", State when and Describe: \_\_\_\_\_
7. (a) Was the dental treatment required because of injury? (YES/NO): Yes  
(If "YES" please complete 7b-7c)  
(b) When did accident happen? They before yesterday Hour: 5 AM/PM: PM  
(c) Describe injuries received: Fractured hand and minor injuries
- If treatment was for injury, was accident caused by Patient's employment? (YES/NO): Yes
8. Is Patient covered through any other plans (including Auto Insurance) which provide Medical or Dental Benefits or Services? (YES/NO): No  
If "YES", Give (a) Name of Insurance Company: Manomay Consultancy Services  
(b) Name of Association/Company or Plan insured under: Orient Company

I/(We) certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief.

I/(We) hereby agree to reimburse the Insurance Corporation of Barbados Limited to the extent of the amount paid on this Claim under any occupational policy provision in the event benefits are provided under any Workmen's compensation law or similar legislation.

I/(We) hereby authorize any Insurance Company, Pre-payment Organization, Employer, Union, Trust Fund, Hospital or Physician to release all information with respect to me or any other Plan providing Benefits or Services. A photo copy of this authorization shall be considered as effective and valid as the original.

Date (DD/MM/YY): 07/09/93

Signature of Insured Member: John Signature of Spouse: Marry