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*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): JAMES WILLAM SON
2. (a) INSURED'S ADDRESS: P.O. BOX-126, WILLIAM STREET, HOLI FOX
   (b) TELEPHONE (INCLUDING AREA CODE): +012-85643116S
   (c) EMAIL ADDRESS: JAMES WILLIAM@gmail.Com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 04/04/2001 (b) GENDER (MALE/FEMALE): MALE
4. (a) INSURED'S POLICY NO. : I19PVB1010
   (b) INSURED'S CERTIFICATE NO. : I19PVB1010
5. EMPLOYER'S/ GROUP'S NAME: SENIOUR STAF
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) NO

(If "YES" please complete 7a –7c)

7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL) :
   (b). OTHER INSURED POLICY OR GROUP NUMBER :
   (c). OTHER INSURED'S DATE OF BIRTH (DD/MM/YY):

PATIENT INFORMATION

8. PATIENT'S NAME (LAST, FIRST, INITIAL): JAMES
9. PATIENT'S ADDRESS: P.O.BOX : 654, MASSAU, NEW PROVIDENCE
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 04/02/96 (b) GENDER (MALE/FEMALE): MALE
11. PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☑
12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT (CURRENT OR PREVIOUS) (YES/NO): NO
    B. AUTO ACCIDENT (YES/NO): YES C. OTHER ACCIDENTS (YES/NO): NO
    Kindly describe on a separate sheet

DECLARATION BY THE INSURED

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

SIGN: INSURED JAMES WILLAM SPOUSE (IF PATIENT) ANDREW HENRY DATE (DD/MM/YY): 04/04/2001

14. VERIFIED BY POLICYHOLDER/PLAN ADMINISTRATOR (TO BE COMPLETED BY PLAN ADMINISTRATOR)

Effective Date of Insured's coverage (DD/MM/YY): 04/03/02 Effective Date of Dependant's coverage (DD/MM/YY): 08/06/2003

SIGNED: James COMPANY STAMP: DATE (DD/MM/YY): 09/01/11