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*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

VISION INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Mia Matthew

2. (a) INSURED'S ADDRESS: P.O.Box-127, James William Street, Holifor

(b) TELEPHONE (INCLUDING AREA CODE): +012-912161543

(c) EMAIL ADDRESS: Mia@gmail.com

3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 05/06/10 (b) GENDER (MALE/FEMALE): female

4. (a) INSURED'S POLICY NO. : N19SVB1212

(b) INSURED'S CERTIFICATE NO. : N19SVB1212

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): Willam

9. PATIENT'S ADDRESS: P.O.Box:777 Brockton Avenue, Abington MA 2351

10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 09/09/99 (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 Mia Matthew SPOUSE (IF PATIENT) Henry DATE (DD/MM/YY): 02/02/02

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

Effective Date of Insured's coverage (DD/MM/YY): 01/01/01 Effective Date of Dependant's coverage (DD/MM/YY): 01/01/2003

SIGNED: Mia COMPANY STAMP: DATE (DD/MM/YY): 01/01/2004