icbl™
Always there
when you need us most

Head Office:
Roebuck St., St. Michael
P.O. Box 1221, Bridgetown,
BB11000, Barbados
t: (246) 434-6000 / f: (246) 426-3393
e: icb@icb.com.bb
w: www.icbl.com
VAT Registration Number:
20092283

Branch Offices:
Emerald City, Six Roads, St. Philip
t: (246) 434-6009 / f: (246) 434-6098
Carlton Complex, Black Rock, St. Michael
t: (246) 434-6008 / f: (246) 434-6099

DENTAL INSURANCE CLAIM FORM

INSURED MEMBER'S STATEMENT

1. Name of Company/Association: Easton Company Services
2. Insured Member's Name: Mary Hodson
3. Date of Birth (DD/MM/YY): 22/08/1996 Patient's Relationship to Insured: Husband
4. Name of attending Dentist: Miles Kaleb
5. When did symptoms of this complaint first appear? Before two weeks
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? 5days Before Hour: 2 AM/PM: PM

   (c) Describe injuries received: fractured Mouth

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: Accenture Consultancy Services

(b) Name of Association/Company or Plan insured under: Oriental National Services

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): 09/10/12

Signature of Insured Member: Mary Signature of Spouse: Killey.