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

*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): K. Sahil
2. (a) INSURED'S ADDRESS: Russell St, Hadley MA 1035
   (b) TELEPHONE (INCLUDING AREA CODE): +1 85161217
   (c) EMAIL ADDRESS: SahilSai@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 01/01/2001 (b) GENDER (MALE/FEMALE): Male
4. (a) INSURED'S POLICY NO. : $02abc5234
   (b) INSURED'S CERTIFICATE NO. : $02abc5234
5. EMPLOYER'S/ GROUP'S NAME: Senior Manager
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): Rahul
9. PATIENT'S ADDRESS: P.O.BOX: 654, Nassau, New Providence
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 04/03/97 (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 Sai SPOUSE (IF PATIENT) Rahul DATE (DD/MM/YY): 05/05/02

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

Effective Date of Insured's coverage (DD/MM/YY): 05/06/02 Effective Date of Dependant's coverage (DD/MM/YY): 05/06/03

SIGNED: Sai COMPANY STAMP: DATE (DD/MM/YY): 09/02/11