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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): DANIEL Anthony
2. (a) INSURED'S ADDRESS: P.O.Box:127 James Street, Abington Ma 2351
   (b) TELEPHONE (INCLUDING AREA CODE): +012-7981990 76
   (c) EMAIL ADDRESS: Danielanthony@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 15/07/2002 (b) GENDER (MALE/FEMALE): Male
4. (a) INSURED'S POLICY NO. : J20ACB0202
   (b) INSURED'S CERTIFICATE NO. : J20ACB0202
5. EMPLOYER'S/ GROUP'S NAME: 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): EMMA
9. PATIENT'S ADDRESS: 30 Memorial Drive, Avon MA 2322
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 13/07/2002 (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): No C. OTHER ACCIDENTS (YES/NO): Yes
    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 EMMA SPOUSE (IF PATIENT) Sipps DATE (DD/MM/YY): 12/07/91

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

Effective Date of Insured's coverage (DD/MM/YY): 03/04/02 Effective Date of Dependant's coverage (DD/MM/YY): 08/09/2006

SIGNED: EMMA COMPANY STAMP: DATE (DD/MM/YY): 07/03/12