



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

VISION INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Mary Hudson
2. (a) INSURED'S ADDRESS: P.O. Box 180 North King Street, Northhampton MA 1060
(b) TELEPHONE (INCLUDING AREA CODE): +093-741659129
(c) EMAIL ADDRESS: Mary@gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 05/08/75 (b) GENDER (MALE/FEMALE): Female
4. (a) INSURED'S POLICY NO.: K02ACB0609
(b) INSURED'S CERTIFICATE NO.: K02ACB0609
5. EMPLOYER'S/ GROUP'S NAME: Manager
6. IS COVERAGE PROVIDED BY ANY OTHER PLAN? (YES/NO) No
7. (a) OTHER INSURED'S NAME (LAST, FIRST, INITIAL): _____ (If "YES" please complete 7a -7c)
(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): Andrews
9. PATIENT'S ADDRESS: 30 Memorial Drive, Avon MA 2326
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 05/08/69 (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 James SPOUSE (IF PATIENT) Hudson DATE (DD/MM/YY): 05/12/93

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

Effective Date of Insured's coverage (DD/MM/YY): 08/04/15 Effective Date of Dependant's coverage (DD/MM/YY): 09/06/03

SIGNED: Andrews COMPANY STAMP: _____ DATE (DD/MM/YY): 11/01/2008