icbl™
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DENTAL INSURANCE CLAIM FORM

INSURED MEMBER'S STATEMENT

1. Name of Company/Association: Microsoft Private Ltd
2. Insured Member's Name: Lydia Mark
3. Date of Birth (DD/MM/YY): 21/09/1994 Patient's Relationship to Insured: Father
4. Name of attending Dentist: Bryan Riley
5. When did symptoms of this complaint first appear? Before 10 days
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? day before Yesterday Hour: 5 AM/PM: AM

   (c) Describe injuries received: Fractured Leg and Major Injuries

   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: Mozila Consultancy Services

   (b) Name of Association/Company or Plan insured under: Oriented Banking 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): 10/01/11

Signature of Insured Member: Lydia Mark Signature of Spouse: Maxwell