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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): SUZAN ROCK

2. (a) INSURED'S ADDRESS: P.O.BOX - 166 , RICK LANES , HOLI FOX

(b) TELEPHONE (INCLUDING AREA CODE): +012 - 998548612

(c) EMAIL ADDRESS: SUZAN ROCK@gmail.Com

3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 04/08/14 (b) GENDER (MALE/FEMALE): FEMALE

4. (a) INSURED'S POLICY NO. : I19PVB1010.

(b) INSURED'S CERTIFICATE NO. : I19PVB1010

5. EMPLOYER'S/ GROUP'S NAME: JUNIOR STAF

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): SUZAN ROCK

9. PATIENT'S ADDRESS: P.O.BOX - 166 , WILLIAM STREET , NEWYORK

10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 04/11/14 (b) GENDER (MALE/FEMALE): FEMALE

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 SUZAN ROCK SPOUSE (IF PATIENT) SAMANTHA DATE (DD/MM/YY): 08/02/93

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

Effective Date of Insured's coverage (DD/MM/YY): 09/06/93 Effective Date of Dependant's coverage (DD/MM/YY): 06/09/93

SIGNED: Suzan COMPANY STAMP: DATE (DD/MM/YY): 09/10/93