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*PLEASE USE BLOCK CAPITALS TO FILL THE FORM

MEDICAL INSURANCE CLAIM FORM

INSURED INFORMATION

1. INSURED'S NAME (LAST, FIRST, INITIAL): Zoey Nathan
2. (a) INSURED'S ADDRESS: 66-4 Parkhurst Rd, Chelmsford MA 1824.
   (b) TELEPHONE (INCLUDING AREA CODE): +011 - 5846113 56
   (c) EMAIL ADDRESS: Zoey Nathan @gmail.com
3. (a) INSURED'S DATE OF BIRTH (DD/MM/YY): 05/06/2000 (b) GENDER (MALE/FEMALE): Male.
4. (a) INSURED'S POLICY NO. : Z20PAB2020
   (b) INSURED'S CERTIFICATE NO. : Z20PAB2020
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): Zoey
9. PATIENT'S ADDRESS: P.O.Box :- Northking Street, Northampton MA 1060
10. (a) PATIENT'S DATE OF BIRTH (DD/MM/YY): 08/05/98 (b) GENDER (MALE/FEMALE): M 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 Zoey Nathan SPOUSE (IF PATIENT) Henry Andrew DATE (DD/MM/YY): 05/06/2000

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

Effective Date of Insured's coverage (DD/MM/YY): 05/06/05 Effective Date of Dependant's coverage (DD/MM/YY): 08/05/2005

SIGNED: Zoey COMPANY STAMP: DATE (DD/MM/YY): 10/03/12