VINSURE
ST. VINCENT INSURANCES LTD

HEALTH CLAIM FORM

Remember to attach original receipts/itemized bills
Notification and proof of claim must be submitted within 90 days

◯ HEALTH ◯ VISION ◯ DENTAL

1. TO BE COMPLETED BY EMPLOYER/INDIVIDUAL POLICY HOLDER

Policy No.: _____ ID No.: _____

Policy Holder: _____

Sign below if claim is being processed by an HR Officer

2. TO BE COMPLETED BY EMPLOYEE/INSURED (PLEASE PRINT)

Employee's/Insured's Name: _____ Patient's Name: _____

Date of Birth: ____/____/____ (DD/MM/YY) Relationship to Insured: _____ Name of Spouse's Employer: _____

Address: _____ Telephone No.: _____

Is patient's condition related to: a. Employment Yes ◯ No ◯ b. Auto Accident Yes ◯ No ◯ c. Other Accident Yes ◯ No ◯

If yes, Give Details _____

Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? Yes ◯ No ◯

If Yes, give (a) Name of Insurance Company _____

(b) Name of Group or Company insured under _____

AUTHORISATION: (Must be completed)
I hereby authorize any doctor, institution, organisation or person who has treated me to release all health information acquired in the course of my examination or treatment to St. Vincent Insurances Limited.

Insured's Signature _____

Patient's Signature _____

Date _____

ASSIGNMENT OF BENEFITS:
I hereby authorize and direct St. Vincent Insurances Limited to pay all benefits accruing to me, as a result of this claim and to the extent of invoices submitted, to the undersigned physician or supplier of services.

Insured's Signature _____

Date _____

3. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER

Patient's Name: _____ Name of Referring Physician _____

Name & Address of Doctor/Health Provider: _____

Diagnosis or nature of illness or injury (ICD CODE) 1._____ 2._____ 3._____ 4._____

Is condition due to Pregnancy? Yes ◯ No ◯ If Yes, give approximate date of Last Monthly Period: _____

4. TO BE COMPLETED BY DOCTOR- MEDICAL/SURGICAL TREATMENT

Date of first symptoms: _____ Has patient been previously treated for this condition? Yes ◯ No ◯

Date of first consultation for this condition: _____ If Yes, Give date: _____

A	B	C	D	E	
Date DD/MM/YY	Place of Service (Office/Home/Hosp.)	Procedures, Services or Supplies (Explain unusual circumstances)	Diagnosis 1, 2, 3, 4	Charges $	¢

Further Services Recommended	Surgical Procedure	$	¢
	Date of Operation: Name of Surgeon:		
	Type of Operation:		
	Name of Assistant Surgeon:		
	Name of Anesthetist:		
	TOTAL		

I hereby certify that the above services as indicated by date have been completed.

_____ Official Stamp

_____ Signature of Doctor

_____ Date

5. TO BE COMPLETED BY HOSPITAL

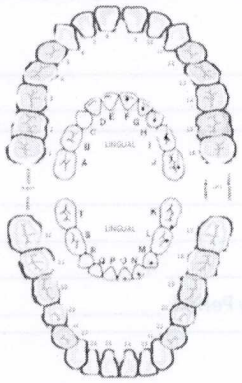
	Charges $	Charges ¢
No. of days confined: ◯ Private ◯ Semi-private ◯ Ward		
Daily hospital charge for patient: ($) From: To:		
Operation or delivery room (state type of operation):		
Hospital services:		
Name of admitting Doctor:		

6. TO BE COMPLETED BY LABORATORY/X-RAY DEPARTMENT

Date and type(s) of test(s)		

7. TO BE COMPLETED BY DENTIST

Dentist:		If Yes, enter brief description and dates below If crown, was tooth badly broken down? Yes ◯ No ◯	
Address:		Is treatment a result of occupational illness or injury? Yes ◯ No ◯	
Telephone No.:		Is treatment a result of auto accident? Other Accident? Yes ◯ No ◯	
First visit date (DD/MM/YY)	Place of treatment: ◯ Hospital ◯ Office ◯ Other	X-rays or models enclosed? Yes ◯ No ◯	How many?
If prosthesis, is this initial placement? Yes ◯ No ◯	If Yes, give date of extractions of teeth being replaced. _____	If No, give reason for replacement and date of prior placement.	



Indicate missing teeth with an X

Examination and treatment plan. List in order. Use charting system shown.

Date of Service (DD/MM/YY)	Tooth # or Letter	Tooth Surface	Description of Service	Charges $	Charges ¢

◯ Predetermination/Estimate ◯ Actual TOTAL

8. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST

Diagnosis	Date of Service (DD/MM/YY)	Description of Service	Charges $	Charges ¢
		(A) Examination		
		(B) Frames		
		(C) Lenses (please specify type below)		
		(D) Tinting		

◯ Single ◯ Bi-focal ◯ Lenticular ◯ Contact Lenses

(a) If Contact Lenses, were they prescribed for severe corneal astigmatism, corneal scarring, keratoconus or aphakia? Yes ◯ No ◯
Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? Yes ◯ No ◯
Can visual acuity be improved by up to at least the 20/70 level by contact lenses? Yes ◯ No ◯

(b) Are these prescription sunglasses? Yes ◯ No ◯
Replacement of LOST or DAMAGED GLASSES? Yes ◯ No ◯

TOTAL EXPENSES		

9. THIS FORM MUST BE SIGNED BY DENTIST/OPTOMETRIST/AUTHORISED PERSON

I hereby certify that the above services as indicated by date have been completed.

Official Stamp _____ Signature of Provider _____ Date _____