



GROUP MEDICAL, DENTAL AND VISION MEMBER'S STATEMENT OF CLAIM

REGIONAL SERVICE CENTRE: _____

MEMBER NO.: _____

CLAIM NO.: _____

DATE SUBMITTED: _____
dd / mm / yy

1 Member Surname: _____ NIS#: _____

First Name _____ Middle Name or Initial _____ Date of Birth dd / mm / yy

2 Home Address: _____ Tel: _____

3 Patient Surname: _____

First Name _____ Middle Name or Initial _____

4 Ailment / Sickness: _____ Date of Ailment / Sickness: _____
dd / mm / yy

5 Have you had this ailment before? [] Yes [] No If 'Yes' state when: _____
dd / mm / yy

6 Did your ailment arise from you employment? [] Yes [] No If 'Yes' state when: _____
dd / mm / yy

7 Do you have any other medical coverage? [] Yes [] No If 'Yes' state where: _____

Name of person covered under

(a) _____ Date of Birth: _____
Surname First Name dd / mm / yy

(b) Name of Employer: _____

(c) Insurance Company: _____

8 ASSIGNMENT OF BENEFITS

(a) Hospital Confinement Benefit

I authorise payment of my medical benefit entitlement for eligible hospital expenses to be paid to _____ for the services provided for the period
from _____ to _____

(b) Surgical Benefit

I authorise payment of my medical benefit entitlement for eligible surgical expenses to be paid to _____ for the services provided for the period
from _____ to _____

Statements/bills are attached to support my claim and I understand and agree that all charges not covered by my medical plan shall be borne by me.

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and belief. I hereby authorise all doctors who treated me and all hospitals or institutions that provided medical services to furnish full information if requested by M&M Insurance Broking Services Limited for the purpose of settling this claim

Date: _____ dd / mm / yy Member's Signature: _____

ATTENDING PHYSICIAN'S / DENTIST / OPHTHALMOLOGIST

(Please complete this form and give to your patient)

Patient's Name: _____ Date of Birth: _____ Sex: Male Female
A. DOCTOR'S VISIT

Visit Date (dd/mm/yy)	Where? (Office Institution (H)home)	Diagnosis (Describe any Complications)	Cost of Visit	Quantity & Strength of Service Provided (Specify Trade Name of Controlled Drugs)	Cost of Other Services	Further Services Recommended (Referrals, Confinement etc)	Doctor's Signature	Specialist (Yes (N)o)

B. SURGERY Please provide explanation for any charges in excess of the normal and customary level

Visit Date (dd/mm/yy)	Describe Procedure(s) including any complications	Duration of Surgery	Surgeon	Surgery Fee	Anaesthesia	Anaesthetic Fee

C. MATERNITY

Date of Pregnancy (dd/mm/yy)	Date of Delivery (dd/mm/yy)	Obstetrician	Obstetrical Fee	Maternity Clinic	Period of Confinement

Dentist's Name: _____ Phone: _____ Fax: _____
 Address: _____ Email: _____

Dental Treatment was requires because of: _____ Date of Injury: _____ dd / mm / yy
 Occupational Injury? Accidental Injury? Description of Injury: _____

Examination & Treatment Record - Use Charting System Shown

Tooth # or Letter	Surfaces	Description of Service (including x-rays, prophylaxis materials used etc.)	Date Service Performed (dd/mm/yy)	Fee	

INDICATE MISSING TEETH WITH AN 'X'
 REMARKS FOR UNUSUAL SERVICES

I hereby certify that the services listed above have been performed. Date: _____ Dentist Signature: _____
 dd / mm / yy