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: ____________________ dd / mm / yy

Surname ______ First Name ______

(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 / OPTHALMALOGIST

(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? (O)ffice (I)nstitution (H)ome	Diagnosis (Describe any Complications)	Cost of Visit	Quantity & Strength Service Provided (Specify Trade Name of Controlled Drugs)	Cost of Other Services	Further Services Recommended (Referrals, Confinement etc)	Doctor's Signature	Specialist (Y)es (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	Anaesthesis	Anaesthetic Fee

C. MATERNITY

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

Dentist's Name: ______________________ Phone: ______________ Fax: ______________

Address: ______________________ Email: ______________

Dental Treatment was required because of: ______________________ Date of Injury: ______________ dd / mm / yy

Occupational Injury? [ ] Accidental Injury? [ ] Description of Injury: ______________________

INDICATE MISSING TEETH WITH AN 'X'

REMARKS FOR UNUSUAL SERVICES

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

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