Employee Benefits Division
P.O. Box 439, Kingston, Telephone: 929-8920-9, Facsimile: 929-4730

SCHOOLMATE INSURANCE – CLAIM FORM

PART A : THIS SECTION TO BE COMPLETED BY CLAIMANT

1.) NAME OF INSURED (Print full name in BLOCK CAPITAL)	2.) ADDRESS OF INSURED:	3.) FORM/GRADE:
_____	_____ _____	[ ]

4.) NAME AND ADDRESS OF SCHOOL:

_____

_____

STATE:

5a.) HOW DID THE ACCIDENT HAPPEN?	5b.) DATE OF ACCIDENT? _____/_____/_____ DD. MM. YYYY.	5c.) WHERE?
6.) WHERE DOES PARENT/GUARDIAN WORK?	**7.) DO YOU HAVE ANY OTHER INSURANCE?** YES [ ] NO [ ]	

8.) IF YES STATE NAME (S) & POLICY NUMBER(S)

A.)_____ #_____ **B.)** _____ _____

C.)_____ #_____

DOCTOR(S) CONSULTED:

NAME	ADDRESS	DATE CONSULTED

I hereby certify that the foregoing answers are true and correct to best of my knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to SAGICOR LIFE JAMAICA LIMITED. I understanding that I / we / parents are financially responsible for charges not covered by the group policy.

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Date ***Principal's / Parent or Guardian's Signature (not to be signed by minor)***

PART B: - THIS SECTION MUST BE COMPLETED BY SCHOOL (POLICYHOLDER)

CLAIMANT'S NAME:		EFFECTIVE DATE OF CLAIMANT'S INSURANCE
NAME OF SCHOOL (POLICYHOLDER)	POLICY #:	DO YOU RECOMMEND PAYMENT OF THIS CLAIM YES [ ] NO [ ]

_____ ____/_____/_____ _____

Principal/Bursar's (Print Full Name) **Dd. Mm. Yr.** **Signature**

_____ _____

(Affix School Stamp) **Title**

DO NOT FORGET TO ATTACH ORIGINAL ITEMIZED BILLS AND RECEIPTS

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME:	**DATE OF BIRTH:** _____/_____/_____ Dd. Mm. Yr.
NAME OF PARENT OR GUARDIAN	

PLEASE GIVE DETAILS OF THE FOLLOWING:

1.) NATURE OF INJURY

2 a.) HOW DID THE ACCIDENT HAPPEN?	**2 b.) WHERE?**	**DATE OF INJURY** DAY MTH YR

3 a.) NATURE OF PROCEDURE PERFORMED (IF ANY)	**3 b.) DATE PERFORMED** DAY MTH YR

4 a.) CHARGES FOR THIS PROCEDURE	**4 b.) WHERE PERFORMED** _____ If in a Hospital, In-patient [ ] Out-patient [ ]	**Charge Per Visit?**

GIVE DATES OF TREATMENT :

DATE:	**NO. OF VISITS**

Is further operative procedure anticipated? YES [ ] NO [ ]	**If Yes explain**

Is patient under your care? YES [ ] NO [ ]	**If discharged, give dates.** _____/_____/_____ _____/_____/_____ _____/_____/_____
If fracture or dislocated, state whether complete or incomplete	**If fracture of long bones, state type and location** _____
Was it confirmed by an X-ray?	

REMARKS

_____

_____

_____

……../……./……..…… ……..…….. ……..……..

Date **Print Name** **Signature & Stamp (Physician /Surgeon)**

_____ _____ _____

Medical Complex **Street Address** **City or Town**

PLEASE REMEMBER TO AFFIX YOUR BUSINESS STAMP