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

EBD-CLM14-08-J01/0608

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

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

____________________ ____________________ ____________________
Medical Complex Street Address City or Town

PLEASE REMEMBER TO AFFIX YOUR BUSINESS STAMP