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.

--------------------------------- *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

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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

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