Dental & Vision Claim Form

RoyalStar House
John F. Kennedy Drive
Nassau, Bahamas

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Part I: Primary Insured Information

To expedite the claim process, please include proof of payment, medical bill(s) and pertinent medical information.
If additional medical information is required, the administrator will request it directly from your doctor.

Last name	First name	I.
Customer number	Email address	Phone (Home/Cell)
Address		DOB Day/Month/Year

Part II: Claimant Information

Last name	First name	I.
DOB Day/Month/Year	Sex ☐ Female ☐ Male	Relationship to primary insured ☐ Self ☐ Spouse ☐ Child
Customer number	Do you have any other health insurance *(If yes, please provide the insurance company information)* ☐ Yes ☐ No	
Name of the insurance company	Address	

Part III: Accident Related Services

Date of injury or accident (Day/Month/Year)	Did the injury occur while working? ☐ Yes ☐ No	Is injury due to automobile accident? ☐ Yes ☐ No
How did injury or accident occur?		

Part IV: Services Provided

Nature of service provided	Date of service *(Day/Month/Year)*
Name of treating physician	Address of physician

I declare the answers to the previous questions are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, insurance company, employer, labor union or association to release information to New Providence Life as is required to properly process this claim. A photostatic copy of this authorization shall be considered valid as the original.

_____ Date _____ /_____ /_____

Signature of primary insured — Day Month Year

(If the insured (patient) is under age, the primary insured shall sign on the patient's behalf)

Dental & Vision Claim Form *(continued)*

Part V: Dental & Vision Services

Date of Services	Describe dental or optical procedure, services and supplies furnished for each date given	Charges	
	Total amount due:		
	Amount paid by patient:		
	Balance due:		

Treating physician name	Phone
Address	Medical license number

_____ Date _____ /_____ /_____

Signature of treating physician — Day Month Year

NOTE: Return this claim form, with original invoices and receipts, within 180 days of treatment. Dependent children, 18-years-old and over, should include a copy of their school certificate. Complete a separate form for each illness or accident.

If you wish to receive your claim payment by wire transfer, please complete the Wire Transfer Form.