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VISUAL IMPAIRMENT CLAIM FORM PRINCIPAL'S STATEMENT

(Note: ALL questions MUST be answered for every claim. NA = Not applicable)

Principal's No.: _____ Group Name: _____ Group Number: _____ Claim No: _____

1. Principal's Name _____ Date of Birth: _____ Sex: Female Male
2. Name of Patient _____ Date of Birth _____ Sex: Female Male
3. Relationship of Patient to Principal: Self Spouse Child Other (Explain) _____
4. Name of Attending Ophthalmologist/ Optometrist _____
5. When did symptoms of this illness first occur? → → → → D ____ /M ____ Y. ____ NA
6. Was treatment necessary because the patient was injured or poisoned? → → → Yes No
7. If patient was injured or poisoned, state the **Date, Time and How** the incident occurred. _____ NA
8. Did patient voluntarily participate in an activity that targeted the patient for abuse or endangerment? → Yes No
9. Is patient entitled to Workmen Compensation or coverage under any other medical plan? → → Yes No
10. If you gave 'Yes' to question 9 above, give name of Company. _____ NA
11. If you gave 'Yes' to question 9 above, has patient made any claim for the relevant benefits? → Yes No NA

I hereby certify that the foregoing answers are true and correct to the 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 **Demerara Mutual Life**. I also understand that only original documents are valid in support of my claim and that once submitted, all documents associated with the expense and other relevant circumstances associated with the loss, becomes the property of the Company. I agree to reimburse **Demerara Mutual Life** to the extent of the amount paid on this claim under any Occupational Policy Provision in the event benefits are provided under any Workmen's Compensation Law or similar Legislation. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Principal's Signature X _____ Patient's Signature (if over 18yrs) X _____

EMPLOYER'S STATEMENT

Employee's Occupation _____ Date Employed _____ AM ¹

If Patient is Employee state the last day of work _____ Hour _____ PM ¹

Has the employee returned to work? Yes ¹ When? _____ No ¹ When expected? _____

Has the employee made claim for Workmen's Compensation? Yes ¹ No ¹ Is he/she entitled to such benefits? Yes ¹ No ¹

Employer _____ By _____ Date _____ 20 _____

FOR OFFICIAL USE ONLY

_____ X _____
 Date Received Recipient's Name (PRINT) Group Administrator's Signature Title

Be certain **ALL** questions are answered and **ALL** information requested is furnished.
 The Attending Ophthalmologist/Optomtrist Statement on the reverse side **MUST** be completed and furnished.

