BAF FINANCIAL INSURANCE (BAHAMAS) LIMITED

GROUP INSURANCE VISION CLAIM FORM

To be completed by the Treating Physician
(PLEASE USE BLOCK LETTERS)

BAF TIN #: 100239418

PART I TO BE COMPLETED AND SIGNED BY THE INSURED

1. Patient's name: (first, middle initial, last)	2. Patient's Birthday (DD/MM/YY)	3. Insured's name (first, middle initial, last)
4. Patient's Full address & Tel. number	5. Patient's Sex Male Female 7. Relationship to Insured Self Spouse Child Other	6.Is the Insured a full time student? Yes No If yes, name & address of school
8. Insured's Policy number	10. Was condition related to: A. Patient's Employment Yes No B. An Accident Yes No	11. If an accident, give date and brief details

9. Does the patient have other vision insurance? **Yes No**

If YES, provide name & address of insurance company, policy number and name of insured

12. The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my doctor to furnish and disclose all facts concerning this claim.

Signature of insured/patient: **Date:**

PART II TO BE COMPLETED BY DOCTOR

Date of examination:	Refraction	
	No Refraction	

If you prescribed glasses, indicate the type:
Single vision bifocal trifocal contacts

Has cataract surgery been performed? **Yes No**
If YES, date:

Can visual activity be restored to at least 20/20 in the better eye with conventional glasses?
Yes No

Is this a prescription change from last year? **Yes**
No

Best corrected visual acuity
R E 20/ LE 20/

RVS no

Examination fee

DOCTOR'S PRESCRIPTION

	Sphere	Cylinder	Axis	Prism	Base
RE					
LE					
Reading Add	RE		LE		

COMMENTS:

SIGNATURE: DATE:

Please type or print name of doctor

Address:

PART III DISPENSER TO COMPLETE

Order date	Delivery date	Glass lens	
		Plastic lens	

Right lens charge $

Left lens charge $

Oversize charge (if any) $

Prism charge other $

Slab off charge _____ $

Tint charge: $

colour ____No. _____

Frame charge $ Name of frame_____

Is frame size over 54MM? **Yes No**

Contact Lens charge **Yes No**

TOTAL for optical materials $

COMMENTS:

SIGNATURE: DATE:

Please type or print name of doctor

Address:

BAF Financial & Insurance (Bahamas) Ltd
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