Premier Health

ATLANTIC MEDICAL INSURANCE LIMITED, Atlantic House, 2nd Terrace & Collins Avenue, P.O. Box SS-5915 Nassau, Bahamas. Telephone: (242) 326-8191 Fax: (242) 326-8189

Atlantic Medical

POLICY No.

CERTIFICATE No.

CLAIM No. OFFICE USE ONLY

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PART 1- EMF				mot duy or				STATE CU	JRRENCY IF	= NOT \$U
	( )	to be completed by	Employee)				L			
ull Name of Emplo	yee/insured	FIRST NAME			MIDDLE INITIAL		L	AST NAME		
ull Name of Patient										
atient's Mailing Add										
atient's Date of Birt	h: DD	MM YY	Gender: M		FEMALE	J				
atient's relationship	to the Insured:	SELF	SPOUSE	CHILD	OTHER					
ame and Address of	of Employer									
· · · · ·	lealth Coverage, e	enter name of policyhc	older and policy numb	ber.						
NAME: YPE OF CLAIM:	MEDICAL	VISION				POLICY	10.			
	L	tient's Employment	: Traffic Ad	ccident:	Pregnancy	y: 🔽 Ot	her:	) (give d	etails belo	w)
Details of Claim										
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		E BENEFITS: (Sig	an only for direct	payment to	hospital or c	loctor)	Date	L		
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