TIP FRIENDLY SOCIETY
80 Half Way Tree Road, Kingston 10
Telephone: 920-8399, 960-0729, 968-5623
Toll Free: 1-888-991-4189

MATERNITY BENEFIT CLAIM

Claimant's Statement

Policy Number: ____________________ **Product/Plan Name:** ____________________

SECTION I: THIS SECTION MUST BE COMPLETED IN FULL BY THE CLAIMANT

Claimant Name: ______________________________ Age: __________

Residential Address: ______________________________

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Contact Numbers: Home ____________________ Mobile ____________________

Name of Employer: ______________________________

Employer Address: ______________________________

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Occupation: ______________________________

Name of Child (1): ______________________________

Sex: ☐ Male ☐ Female Date of Birth: ____________________

Name of Child (2): ______________________________

Sex: ☐ Male ☐ Female Date of Birth: ____________________

Place of Birth: ______________________________

I hereby certify that the foregoing statements are full and true to the best of my knowledge and belief, and I agree that payment according to the terms of the policy shall be a full satisfaction and discharge of claim.

Date: ____________________ 20 ______ ____________________

Claimant's Signature

SECTION II: ATTENDING PHYSICIAN/SURGEON STATEMENT

The Insured is responsible for the completion of this form without expense to the Society.

Name of Patient: ____________________ Date of Birth: ____________________

Length of Pregnancy: ____________________ Date of Delivery: ____________________

Method of Delivery: ☐ Natural Birth ☐ Caesarean Section ☐ Miscarriage

Sex of Child (1): ☐ Male ☐ Female Sex of Child (2): ☐ Male Female

Describe Present Condition of (Mother): ______________________________

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____

Describe Present Condition of (Child/ren): ______________________________

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Comments: ______________________________

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____

Date: ____________________ 20 ______ Physician's Name: ____________________

Physicians Address: ____________________ ____________________

____________________ Physician's Signature:

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This Form **must** be submitted with the **original** copy of Birth Certificate or the Birth Registration.