Application for Chronic Prescription Medicine

Insured's Name:		Date of Birth:	
Company/Group:		Staff #:	
Mobile:		Membership #:	

I herby certify that all information and documents submitted with this Form are complete and true. I herby authorize any Doctor, Hospital, Clinic or Medical Provider, any insurance company, or any other institution, or any other person who has any record or any information about me to provide SEIB with complete information, including copies of Medical Records related to any illness or accident, any treatment, examination, advice or hospitalization

Name of Patient/Insured _____ Signature _____ Date ___/___/___
Day Month Year

A- To be completed by Treating / Attending Physician

Diagnosis	**Since When** (year diagnosed)

Important Note: Please attach copies of current laboratory reports (if available)

Name of Medicine (Generic & Brand Name)	**Dose**	**Frequency**	**Duration**

Where does the patient want to receive his/her medication? (Please specify name of provider)

Attending Physician's Name: Specialty:

Stamp & Signature of Attending Physician _____ Date ___/___/___
Day Month Year

B- To be completed by SEIB Insurance Underwriting Department

Administration Approval ☐ Yes ☐ No ☐ Excess

Comments

Name _____ Signature _____ Date ___/___/___
Day Month Year

C- To be completed by SEIB Insurance Medical Officer - CSC

Approved by Dr: _____ Signature _____ Date ___/___/___
Day Month Year