THE NATIONAL INSURANCE BOARD

Commonwealth of the Bahamas

NATIONAL PRESCRIPTION DRUG PLAN

Registration Form

this form must be accompanied by: a valid Passport or Drivers Licence, NIB Card, Valid Work Permit(where applicable) & Private Health Insurance Card(where applicable)

DP-1

SECTION 1 - TO BE COMPLETED BY CLIENT

MR
MISS
MRS
MS

NI #: | | | | | | | | |

NAME _____
SURNAME FIRST MIDDLE

SEX: Male ☐ Female ☐ BIRTHDATE: ____ / ____ / ____ (DAY / MONTH / YEAR) P.O. BOX: _____

ADDRESS: _____ ISLAND: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

PHONE CONTACT: HOME: _____ WORK: _____ CELL: _____ OTHER: _____

E-MAIL ADDRESS: _____ OCCUPATION: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

NAME OF PRIVATE HEALTH INSURER: _____ POLICY NUMBER: _____

DOES YOUR PRIVATE HEATLH INSURANCE COVER PRESCRIPTION DRUGS? YES ☐ NO ☐

I certify that the information contained in this application is true and correct to the best of my knowledge and belief, and I undertake that if this benefit is awarded I shall inform the National Prescription Drug Plan Office of any change in my condition, which may affect my entitlement to this Benefit.

_____ _____
SIGNATURE OF CLIENT/GUARDIAN DATE

COMPLETE THIS SECTION ONLY IF YOU ARE A GUARDIAN

GUARDIAN NAME: _____ GUARDIAN NI#: _____

RELATIONSHIP TO CLIENT: _____ ID TYPE AND NO: _____

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

I certify that _____ has the following medical condition[s]:
CLIENTS NAME:

CONDITION	✓	CODE	DATE OF DIAGNOSIS
ARTHRITIS			
ASTHMA			
*BREAST CANCER **			
DIABETES MELLITUS			
GLAUCOMA			
HIGH CHOLESTEROL			
HYPERTENSION			
ISCHAEMIC HEART DISEASE			
*MAJOR DEPRESSION**			
*PROSTATE CANCER**			
*PSYCHOSIS**			

* Diagnosis must be made by Specialist

HOME-CARE PATIENT? YES ☐ NO ☐

DOCTOR'S INFORMATION:

NAME: _____

OFFICE ADDRESS: _____

P.O. BOX: _____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

MEDICAL REGISTRATION#: _____

SIGNATURE: _____

↑ PLACE STAMP HERE ↑

SECTION 3 - FOR OFFICIAL USE ONLY:

ID TYPE: Passport ☐ Drivers License ☐ Other _____ ID Number: _____

Is Claimant in receipt of N.I.B. Benefit/Assistance? YES ☐ NO ☐ TYPE: _____

Application Received By: _____ Date: _____