THE NATIONAL INSURANCE BOARD
Commonwealth of the Bahamas
NATIONAL PRESCRIPTION DRUG PLAN
Information Change Form

DP-2

SECTION 1- TO BE COMPLETED BY CLIENT

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

MR.
MISS.
MRS.
NAME: MS._____
SURNAME FIRST MIDDLE

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

ADDRESS: _____ ISLAND: _____

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

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

EMAIL ADDRESS: _____ OCCUPATION: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

NAME OF PRIVATE HEALTH INSURER: _____ POLICY NUMBER: _____

DOES YOUR PRIVATE HEALTH 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 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'S NAME: _____ GUARDIAN'S NI#: _____

RELATIONSHIP TO CLIENT: _____ ID TYPE & NO: _____

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

I certify that _____ has the following medical conditions[s]:
CLIENT'S 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: _____