



The National Insurance Board
Of the Commonwealth of The Bahamas
The National Insurance Act, 1972

For NIB Use Only

Registration Form (DP-1) received? Yes No

Receiving Officer _____

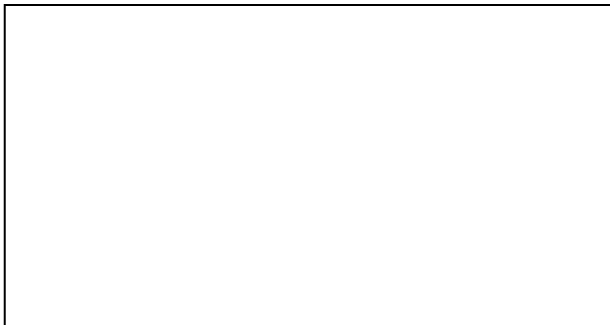
**NATIONAL PRESCRIPTION DRUG PLAN
ANTE-NATAL/POST-NATAL CERTIFICATE**

Section A: Claimant Details *(To be completed by claimant)*

- Mrs.
1. Ms. _____
Last Name First Name Middle Name(s)
2. N.I.#: _____ 3. Date of Birth: _____
dd/mm/yyyy
4. Address: _____
5. City/Settlement: _____ 6. Island: _____
7. Telephone #1: _____ 8. Telephone #2: _____
9. P.O. Box: _____ 10. Email Address: _____

Section B: Confinement Details *(To be completed by physician)*

11. Is claimant pregnant at this time? Yes No
- a) If yes, please indicate expected date of delivery. _____
Comments, if necessary: _____
- b) If no, please indicate actual date of delivery. _____
Comments, if necessary: _____
12. Physician's Signature: _____
Name (please print) Signature
13. Medical Registration #: _____ 14. Date form completed by physician: _____
dd/mm/yyyy



***Please affix physician
stamp in the box at left.***

Section C: Claimant's Declaration

I certify that the information contained in this form is true and correct to the best of my knowledge and belief. 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.

14. Claimant's Signature: _____

15. Date: _____
dd/mm/yyyy

IMPORTANT NOTE

This form MUST be accompanied by a National Prescription Drug Plan Registration Form. (Form DP-1).