**REQUEST FOR APPOINTMENT TO SUBMIT**

**MORE THAN 5 (FIVE) CLAIMS**

**Instructions:**

* Complete form and submit via email to: **appointments@nibtt.net**
* You will receive an email responseto the email from which the request was received **within three (3) business days**

**WHICH SERVICE CENTRE DO YOU WISH TO VISIT?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. NAME OF BUSINESS/ INDIVIDUAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. CONTACT NUMBER (S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. NAME OF PERSON VISITING SERVICE CENTRE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. ID TYPE & NUMBER OF PERSON AT #3 ABOVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. TOTAL NUMBER OF CLAIMS TO BE SUBMITTED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following details of the claims you wish to submit

**CLAIM TYPE NUMBER OF CLAIMS**

SICKNESS BENEFIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MATERNITY BENEFIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL MATERNITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_

INJURY/ DISABLEMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL EXPENSES \_\_\_\_\_\_\_\_\_\_\_\_\_\_

INVALIDITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURVIVOR/ DEATH BENEFIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_

RETIREMENT BENEFIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_