MEDICAL BENEFITS SCHEME

SMART CARD REPLACEMENT FORM

Name of Beneficiary: ________________________ Date: ____________________

Smart Card#: ________________________________ Telephone: _______________________

Old Medical Benefits#: _________________________ Social Security: ______________________

Address: ____

Reason for Replacement: ☐ Lost ☐ Damaged ☐ Stolen ☐ Other__________________

REPLACEMENT FEE: EC $75.00 *

N.B: The fee of EC $75.00 must first be paid to the cashier before replacement card can be processed

CERTIFICATION

I __________________________________certify that the original Smart Card issued to me by the Medical Benefits Scheme was _________________________________as indicated above.

Signature of Applicant: __________________________________ Date: _____________________

OFFICIAL USE

RECOMMENDATION

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Registration Clerk: ____________________________________ Date: ________________________

Approved: **Yes** ☐ **No** ☐

Comments: ____

Registration Supervisor: ___________________________ Date: _______________________________

Production Clerk: _________________________________ Date: _______________________________