Application for chronic prescription medicine

Insured's name	Date of birth
Company/group	Staff #
Mobile #	Membership #

I hereby certify that all the information and documents submitted with this form are complete and true. I hereby authorize any doctor, hospital, clinic, medical provider, insurance company, institution, or any other person who has records or information about me to provide Seib Insurance with complete information, including copies of medical records related to any illness, accident, treatment, examination, advice, or hospitalization.

Name of patient/insured	Signature	Date

To be completed by a treating/attending physician

Diagnosis	Time (year of diagnosis)

Important note: Please attach copies of current laboratory reports (if available)

Name of medication (generic & brand name)	Dose	Frequency	Duration

Where does the patient want to receive his/her medication?
(please specify the name of the provider)

Attending physician's name	Specialty
Stamp & signature of attending physician	Date

To be completed by a Seib Insurance medical officer- CSC

Approved by Dr.	Signature	Date

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