THE NATIONAL INSURANCE ACT, 1972

Commonwealth of the Bahamas

The National Prescription Drug Plan

Information Change Form (DP-2)

SECTION I - TO BE COMPLETED BY APPLICANT

Mr.
Mrs.
NAME: Ms. _____

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

Surname *First Name* *Middle*

SEX: Male ☐ Female ☐ Date of Birth: _____ P. O. Box: _____

dd/mm/yyyy

Address: _____ Island: _____

Phone Contact: Home: _____ Work: _____ Cell: _____

Email Address: _____ Occupation: _____

Employer Name: _____

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 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.

_____ _____

Signature of Applicant/Guardian **Date**

COMPLETE THIS SECTION ONLY IF YOU ARE A GUARDIAN

Guardian Name: _____ Guardian NI# _____

Relationship to Client: _____ ID Type & No _____

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

I certify that _____ has the following medical condition(s):

CONDITION	☑	CODE	DATE OF DIAGNOSIS
Arthritis			
Asthma			
Benign Prostate Hypertrophy			
Breast Cancer*			
Diabetes			
Epilepsy			
Glaucoma*			
High Cholesterol			
Hypertension			
Ischaemic Disease			
Prostate Cancer*			
Psychiatric Illness			
Sickle Cell Anemia			
Thyroid Disease			

* Diagnosis must be made by Specialist. Home-Care Patient? Yes ☐ No ☐

DOCTOR'S INFORMATION

Name: _____

Office Address: _____

P. O. Box: _____

Phone 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 NIB Benefit/Assistance? Yes ☐ No ☐ Type: _____

Application Received by: _____ Date: _____