SOCIAL SECURITY BOARD
P.O. BOX 698
ROAD TOWN, TORTOLA
BRITISH VIRGIN ISLANDS

HOSPITAL MATERNITY EXPENSES

CLAIMANT'S NAME: _____ **S.S.** _____

DATE OF CONFINEMENT: _____

AMOUNT OWED: $_____

AMOUNT PAID: $_____

AMOUNT DUE: $_____

PREPARED BY: _____

TITLE: _____DATE:_____

(HOSPITAL STAMP)