



- NEM PLAN
- NEM PLUS PLAN
- FIRST CHOICE PLAN
- GLOBAL CARE PLUS
- SMART CHOICE PLAN

**Arranged by Alliance Insurance Services Limited**

**HOW TO FILE YOUR CLAIM**

1. You must FULLY complete ALL PARTS of this form and sign the applicable areas.
2. Attach the bills for the medical expense benefits you are claiming. These bills must be itemized and show the patient's name, condition (diagnosis), type of treatment given, date the expense incurred and the charges made.
3. TIME LIMIT FOR SUBMISSION OF CLAIMS WILL BE 90 DAYS FROM THE DATE THE EXPENSES WERE INCURRED

**GROUP CLAIM FORM – EMPLOYEE**

Group Name:		Group Address:		Group #:	Telephone#:
Employee's Name:		Employee's Address:		Employee's ID#	Employee's Date of Birth:
Patient's Name if not Employee:				This claim is on: Myself <input type="checkbox"/> Dependent <input type="checkbox"/> Spouse <input type="checkbox"/>	
<b>Complete for dependent or spouse only:</b>	Date dependant's Coverage began:	Date of Birth:	Relationship to Employee: Spouse <input type="checkbox"/> Dependant son/daughter <input type="checkbox"/>		Patient's Sex: M <input type="checkbox"/> F <input type="checkbox"/>
	Describe nature of sickness:		Date of first symptoms:		
Describe nature of injury:		Date of first injury:			
<b>DOCTORS CONSULTED</b>					
Names		Address		Dates Consulted	
<b>OTHER INSURANCE</b>					
Details of any other applicable Medical Insurance for Claimant:					
<b>Any persons who, knowingly and with intent to injure, defraud, or deceive any employer or employee, Underwriters, or self insured program, files a statement of claim containing any false or misleading information is guilty of a felony.</b>					
<b>I hereby authorise the release to and the use by the Insurers of Guardian Life of the Caribbean (GLOC) any medical or other information needed in processing this claim and certify that the above information is correct. A copy of this authorisation is as valid as the original.</b>					
Date _____			Insured Signature _____		

