Guardian Group
Guardian Life of The Caribbean Limited

MEDICAL HEALTH INSURANCE

Arranged by Alliance Insurance Services Limited

PLAN	☐
PLUS PLAN	☐
FIRST CHOICE PLAN	☐
SMART CHOICE PLAN	☐
GLOBAL CARE PLUS	☐

TIME LIMIT FOR SUBMISSION OF CLAIMS WILL BE 90 DAYS FROM THE DATE THE EXPENSES WERE INCURRED

CLAIM FORM – INDIVIDUAL

PART 1 Insured's and Patient Information

Insured's Name	Certificate/Policy No.	Date of Birth	Sex	I.D. Number
			_ Male __ Female	

Does the Employer provide group insurance:	If yes, is the Patient for this claim covered by the insurance:	Name of Medical Plan	This claim is about
__ Yes __ No	___ Yes ___ No		___ Myself ___ My Spouse ___ My Son (Daughter)

Patient's Name if not the Insured	Date of Birth	Sex
		___ Male __ Female

PART 2 Claims Information

Is this Claim a result of a injury? __ Yes __ No

Date _____ How did it happen? _____

_____

Where did it occur? _____

_____

Was the accident connected with the Patient's Employment?
___ Yes ___ No

Is this Claim a result of sickness? ___ Yes ___ No

When did symptoms begin? _____

When did patient first see a doctor for it? _____

Name of Doctor _____

Address of Doctor _____

_____

PART 3 Other Insurance Information

Is the patient covered by one or more of the following (Include insurance carried by Spouse or other)?

A. Any other group insurance, or any medical plan because of membership in a group?	___ Yes	___ No
B. Any other similar	___ Yes	___ No
C. Any Medical Sponsored by School or College?	___ Yes	___ No
D. Is there coordination of benefits provision in the other group insurance plan?	___ Yes	___ No
E. Any coverage through the Social Security program?	__ Yes	___ No

If the answer of any of the above is "Yes", please give complete information about the plan(s) in space below:

Name and Address of the Other Insurance Company	Name of the Employer, Group or School	Policy Number

PART 4 Authorization for Release of Medical Information

The statements above are true and correct to the best of my belief. I authorise any hospital or physician to supply re-insurers any information requested. Also, I hereby authorise my employer or Underwriters to release to or obtain from any organisation or person or regulatory agency any information, which may be necessary to determine benefits payable under the policy with Underwriters. A photostatic copy of this authorisation shall be considered as effective and valid as the original. Any person who knowingly and with intent to injure, defraud, or deceive Underwriters, files a statement of claim containing any false, incomplete, or misleading information, thereto, commits a fraudulent insurance act, which is a crime subject to criminal prosecution and civil penalties.

Signature of Insured _____ Date _____

PART 5 Authorization for Payment

I hereby authorize payment directly to the hospital indicated on the next page otherwise payable to me. But not exceeding the regular charges of the hospital for this period of hospitalization. I understand that I am financially responsible for any charges not covered by this authorisation.

Signature of Insured _____ Date _____

PART 6

Name of Patient	Age	Sex ☐ M ☐ F	Address

** Admission Date _____ Hour:_____ ☐a.m. ☐ p.m.	Release Date _____ Hour:_____ ☐a.m. ☐ p.m.

Diagnosis of nature or illness as on medical record. Codification _____

** Was the Patient in intensive care?

☐ Yes ☐ No Date: From _____ to _____ Number of days _____

Operation obstetrical methods utilized (Natural and dates) Codification _____

If this claim is due to an accident, please give information below:

Date _____ How did it happen?_____

_____

Where did it occur? _____

** Who paid for the hospitalization?

**Hospital Name _____

Taken from the Medical Record on _____ of _____, 20 _____ Record Number _____

Signed by _____ Title _____

Diagnosis or nature of illness or injury, relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc.

1.
2.
3.
4.

A Date of Service	B* Place of Service	C Fully Describe Procedure, Medical Services or Supplies Furnished for Each Date Given. Procedure Code Identify	(Explain Unusual Services or Circumstances)	D Diagnosis Code	E Charges	F
			TOTAL CHARGES			

I hereby certify that the services listed above have been performed.
Physician's or Suppliers Name, Address & Telephone Number.

Tax ID No. _____

Your Patient's Account No.

I hereby certify that I have reserved from Mr/Ms

_____

the amount of _____ for the services rendered and listed above.

_____
Physician or Supplier Signature

* PLACE OF SERVICE

1- (H)-INPATIENT HOSPITAL
2- (OH)-OUTPATIENT HOSPTIAL
3-(O)-DOCTOR'S OFFICE
4- (H)-PATIENT'S HOME
5-DAY CARE FACILITY (PSY)
6-NIGHT CARE FACILITY(PSY)
7-(NH)-NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9-AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B-OTHER MEDICAL/SURGICAL FACILITY

** COMPLETE IF HOSPITALIZED