LLOYD'S

CARIB CARE - MEDICAL INSURANCE

Arranged by Caribbean Insurers (Health) Ltd., Lloyd's correspondent, underwritten by certain syndicates at Lloyd's

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. If the patient was confined to a hospital, attach the hospital bill.

GROUP CLAIM FORM - EMPLOYEE

Group Name:	Group Address:	Certificate No:	
Employee's Name:	Employee's Address:	Telephone #	Employee's Date of Birth:
Patient's Name if not Employee:		This claim is on: Myself ☐ Dependant ☐ Spouse ☐	
Complete for dependant or spouse only: Date dependant's Coverage began:	Date of Birth:	Relationship to Employee: Spouse ☐ Dependant son/daughter ☐	Patient's Sex
Describe nature of sickness:		Date of first symptoms	
Describe nature of injury:		Date of first injury	

DOCTORS CONSULTED

Names	Address	Dates Consulted

OTHER INSURANCE

Details of any other applicable Medical Insurance for Claimant:

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.

I hereby authorise the release to and the use by the Underwriters at Lloyd's of 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.

Date **Insured Signature**

TO BE COMPLETED BY THE EMPLOYER

Certificate holder's Name Certificate No:

Claimant's Name Effective Date: Termination Date:

Was Claimant Employed When Claim Began? If 'No' please explain
Yes ☐ No ☐

Date	Signature on behalf of Certificate holder by	Title

Patient's Name and Address: (If different from the Insured)	
Was condition related to Yes No A. Patient's Employment ☐ ☐ B. An Auto Accident ☐ ☐	**I Authorise Payment of Medical Benefits to the Physician or Supplier for Service Described Below:** **Signed:** **Date:**

MEDICAL INFORMATION

Date of illness (first symptom) or injury (accident) or Pregnancy (LMP)	Date of First Consultation	Has patient ever had same or similar symptoms?
For services related to hospitalization give hospitalization dates. Admitted Discharged		Name of referring physician
Name and Address of facility where services were rendered (if other than home or office):		Was Laboratory work performed outside your doctor's office? Yes ☐ No ☐

Diagnosis or nature of illness or injury, relate diagnosis to procedure in column D by reference to number 1, 2, 3, etc.
1.
2.
3.
4.

A Date Of Service	B Place Of Service	C Describe Procedure, Medical Services or Supplies Furnished for Each Date Given Procedure Code	Explain Unusual Services or Circumstances (Procedure, Medical Services or Supplies)	Diagnosis Code	Charges $
				Total	

PHYSICIAN OR SUPPLIER STATEMENT

I hereby certify that the services listed above have been performed. Physician's or Supplier's Name, Address & Telephone Number Tax ID No. _____	Accept Assignment ☐ Yes ☐ No Your Social Security No. _____ Your Employer ID No. _____	I hereby certify that I have reserved from _____ The amount of _____ For the services received and listed above. _____ Physician or Supplier Signature

*PLACE OF SRVICES CODES

1-(H) – INPATIENT HOSPITAL
2-(OH) – OUTPATIENT HOSPITAL
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 LAB
B-OTHER MEDICAL/

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