LLOYD'S

CARIB CARE FORM - MEDICAL INSURANCE

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

DENTAL 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: __ Yes __ No	If yes, is the Patient for this claim covered by the insurance: __ Yes __ No	Name of Medical Plan	This claim is about __ 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 _____