# LLOYD'S

## CARIB CARE - MEDICAL INSURANCE

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

### CLAIM FORM – INDIVIDUAL

**PART 1 Insured's and Patient Information**

| Insured's Name | Certificate/Policy No. | Date of Birth | Sex | Telephone 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