RF&G LIFE INSURANCE COMPANY LTD.
Gordon House, One Coney Drive, P.O. Box 1762,
Belize City, Belize C.A.
Ph: 501 221-5143 . www.rfglife.com
Email: info@rfglife.com . claimsadjud@rfglife.com

HEALTH INSURANCE CLAIM FORM

Insured Information	**Patient's Information**
Insured's Name (First, Middle, last)	Patient's Name (First, Middle, last)
Home Address:	Home Address:
Mailing Address:	Mailing Address:
Email Address: Phone #	Email Address : Phone #
Date of Birth: ___/___/___ dd/mm/yr Policy No:	Date of Birth: ___/___/___ dd/mm/yr Sex: M__ F__
Sex: M__ F__ Marital Status: Single __ Married __Other__	Relationship to Insured: Self___ Spouse ___ Dep Child ___
Is Patient's condition related to: Employment injury___ Auto Accident ___ Other Accident ____	

Employer's Information

Name of Employer	Name of Employer
Address of Employer	Address of Employer
Phone No: Email	Phone No: Email:
Is patient entitled to employment injury benefit? Yes___ No ___	Is patient entitled to employment injury benefit? Yes___ No ___
Authorized Personnel Signature	Authorized Personnel Signature

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, other persons who treated me and all other hospitals or other institutions to furnish full information, including full copies of the records regarding this claim to RF&G Life Insurance Company Ltd.

Insured's Signature **Patient's Signature**

Assignment of Insurance Benefits (*benefits can only be assigned for direct payment to a hospital or to a doctor).*

I hereby authorize payment directly to the hospital, and physician where applicable, named on the attached claim form, of the Insurance Benefits under Policy, otherwise payable to me but not exceed the regular charges for the treatment and/ or services supplied. I understand that I am financially responsible for charges not covered by the Policy.

Insured's Signature **Patient's Signature**

Important: Itemized bill and breakdown of services must be included on submission of a claim.
Claims must be submitted to RF&G Life Insurance within 90 days from the date of loss/injury.

Physician Statement

Date of injury or illness: dd____/mm___/yr____	Date patient first consult: dd____/mm___/yr____
Is condition due to pregnancy? Yes____ No ____	Was patient referred to you ? Yes____ No ____
If Yes, What is date of conception? dd____/mm____/yr____	If yes, by Whom? _____

Has patient ever had same or similar condition? Yes____ No _____

Diagnosis or Nature of Illness or injury:

1._____ 2._____

3._____ 3._____

Is further procedures anticipated? Yes ____ No _____
If yes, explain _____

Remarks _____

_____

Physician's Registration #_____ Physician's Name_____ Physician's Signature_____

Medical Procedures /Hospitalization Information

For services related to a hospitalization, give hospitalization dates:

Admission Date: dd____/mm___/yr____	Discharge Date: dd____/mm___/yr____

Date of Service To dd/mm/yr	Date of Service From dd/mm/yr	Place of Service	Procedures, Services or Supplies	Bill Charges	Rendering Physician

Provider Billing Information

Signature of Physician or Supplier	Service/Facility Location	Billing Provider Info	Accept Assignment Yes____ No____