Administered by:

CG | BRITCAY

HEALTH SERVICES AUTHORITY
CAYMAN ISLANDS
Caring People. Quality Service.

HEALTH CLAIM FORM

Claim No. _____

Group Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_KY@cgcoralisle.com or via Fax to 345 945 0658.

PART 1 To be completed by the EMPLOYEE/RETIREE (please print)

Full Name of Employee/Retiree _____

Policy No. 039001- _____ Certificate No. _____

Name of Employer Health Services Authority _____

Full Name of Patient _____

Patient's Mailing Address _____

Patient's Date of Birth (DD/MM/YY) _____ Patient's Gender ☐ Male ☐ Female

Relationship to Employee/Retiree ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If you have any other Health Insurance coverage, provide name of policy holder and policy number _____

Was sickness/injury related to ☐ Patient's employment ☐ Traffic Accident ☐ Pregnancy ☐ Other (give details below)

_____

DECLARATION:

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

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS (SIGN ONLY IF REQUESTING DIRECT PAYMENT TO HOSPITAL OR DOCTOR):

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

Patient's or Authorised Person's Signature _____ Date _____

PART 2 To be completed by the ATTENDING PHYSICIAN (Provide a separate claim form for itemized account by each attending physician.)

Date of illness (first symptom), injury (accident) or pregnancy (DD/MM/YY) _____

Date patient first consulted you for this condition (DD/MM/YY) _____

Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Name of referring physician or other source _____

Hospitalisation dates (if applicable) Admitted _____ Discharged _____

Name and address of facility where services rendered (if other than home or office) _____

_____

Was laboratory work performed outside your office? ☐ Yes ☐ No

Was the following operation(s) to correct a condition detrimental to the patient's health? ☐ Yes ☐ No

Diagnosis or Nature of Illness/Injury _____

_____

_____

_____

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DATE OF SERVICE	PLACE OF SERVICE*	PROCEDURE CODE	FULL DESCRIPTION OF TREATMENT FOR EACH DATE GIVEN	DIAGNOSIS CODE	CHARGES	DAYS/UNITS	TYPE OF SERVICE*

*PLACE OF SERVICE
1 - IH = Inpatient Hospital
2 - OH = Outpatient Hospital
3 - O = Doctor's Office
4 - H = Patient's Home
5 - IL = Independent Laboratory

Patient's Account Number	Total Charges	Amount Paid	Balance

DECLARATION OF PHYSICIAN OR SUPPLIER:

I certify that the statements on this form are true and complete to the best of my knowledge.

Full Name _____ Telephone _____

Mailing Address _____

Signature _____ Date _____

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
PO Box 74, Grand Cayman, KY1-1102 Cayman Islands | Tel 345 949 8699 | Fax 345 945 0658 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

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