RF&G LIFE INSURANCE COMPANY LTD.
Gordon House
One Coney Drive, P.O. Box 1762, Belize City, Belize C.A.
Ph: 501 221-5118 or 221-5143
Email: info@rfglife.com or claims@rfglife.com Website: www.rfglife.com

DENTAL & VISION INSURANCE CLAIM FORM

Insured Information	**Patient Information**
Insured's Name (First, Middle, last)	Patient's Name (First, Middle, last)
Home Address:	Home Address:
Mailing Address:	Mailing Address:
Policy No: Card ID#: Email address:	Card ID#: Email Address
Date of Birth: dd/mm/yy ___/___/___ Sex: M___ F___	Date of Birth: dd/mm/yy ___/___/___ Sex: M___ F___
Marital Status: Single __ Married __Other (specify) ___	Relationship to Insured: Self___ Spouse ___ Child ___
Phone: Cell: Email:	Do you have another health insurance plan? Yes___ No___ If yes, state name of insurer:

Is Patient's condition related to: Employment injury___ Auto Accident ___ Other Accident ____	
Employer's Information (*For Groups Only*)	
Name of Employer	
Address of Employer	
Is patient entitled to employment injury benefit? Yes___ No ___ If yes, state date claim was submitted to Social Security:	
Print Name of Group Administrator:	**Signature of Group Administrator:**

Medical Release Authorization

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all physicians, other persons who treated me and all other hospitals / institutions to furnish full information, 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 to be made directly to the hospital, or physician where applicable, as named on the attached claim form of the Insurance Benefits 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 charges not covered by the Policy.

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

Important: **Original 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.

To Be Completed by Dentist

Indicate Type of Service: Preventative/Diagnostic ____ Basic Restorative ____ Major Restorative ___ Orthodontics ____

Identify Teeth with an 'X'	Tooth #	Surface	Description of Services	Date of Service mm/dd/yr	Cost of Service
				Total:	
				Amount Paid:	
				Balance due:	

Print Physician's Name_________________________ Physician's Signature/ stamp________________________________

For Vision Services Only

Provider Name:	Phone: Cell:
Address:	Email:

Type of lenses: Single___ Bifocal___ Multifocal___ Lentricular___ Contacts___

Diagnosis	**Date of Service**	**Description of Services**	**Cost of Service**
		Total	

Explanation of Benefit Disbursement Instructions

Tick appropriate option

Pick up from insurer ☐

Mail ☐

Email ☐

Pick up by whom:_______________________________

Mailing address:_______________________________

____

Email Address: _______________________________

Preferred Option for benefit payment

Tick the appropriate option

Pick up From insurer ☐

Mail ☐

Direct deposit ☐

(for direct deposit, kindly complete our online bank authorization form available on our website or from our customer service department

Pick up by whom:_______________________________

Mailing address:_______________________________

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