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

HEALTH 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#:	Card ID#: Cell#: Email:
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:	State name of other health insurance plan:
Is Patient's condition related to: Employment injury☐ Auto Accident ☐ Other Accident ☐	
Employer's Information	
Name of Employer	
Address of Employer	
Is patient entitled to employment injury benefit? Yes☐ No ☐ If yes, state date 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.

Attending Physician Statement

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

Diagnosis or Nature of Illness or injury:

1._____ 2._____

3._____ 4._____

Explain any similar condition that patient has ever had

_____

_____

Explain further procedures anticipated

_____

Other Remarks

_____

_____

Print Physician's Name_____ Physician's Signature/Stamp_____

Medical Procedures /Hospitalization Information Only

Date of service Admission dd/mm/yr	Date of Service Discharge dd/mm/yr	Place of Service	Procedures, Services or Supplies	Bill Charges	Rendering Physician

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:_____

_____