RF&G LIFE INSURANCE COMPANY LTD.
Gordon House
One Coney Drive, P.O. Box 1762, Belize City, Belize C.A.
Ph#: 501 221-5143 . Fax#: 501 223-7345 . www.rfglife.com
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ACCIDENTAL INJURY CLAIM FORM

Section 1: Employer's Statement (*Group Only*)

Employer's Name	Group Policy No:
Employer's Address:	Effective Date of Coverage
	Phone No: Fax No:
Name and Title of Authorized Representative	Signature of Authorized Representative

Section 2: Insured's Information

Name of Insured: (First, Middle, Last)	Social Security No:
Address of Insured:	Card No:
Occupation:	Date of Birth: dd/mm/yr___/___/___ Sex: M___/ F___

Section 3: Details of the Accident

Date and Time of the Accident	Location of the Accident
Full description of the Accident	

Section 4: Authorization

Medical Release Authorization

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:_______________________________

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 the 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 _________________________________

Section 5: Attending Physician

Name of Patient: (First, Middle, Last)

What date did you first examine and treat this Patient?

Had the Patient previously had medical attention for this injury? Yes___ No ___
If yes, by whom?

Describe the injury and its affected part(s).

What complications, if any, have arisen?

What surgery, if any, has been performed?

Was the injury described above of itself and independent of all other causes solely for the loss? Yes___ No ___
If No, give the particulars of any contributing cause or causes:

Was the patient under the influence of alcohol and /or other drugs at the time of the accident or injury? Yes___ No ___

Print Physician's Name___________________________ Physician's Signature and Stamp_______________________________

Section 6: Medical Procedures /Hospitalization Only

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

Date of Service (dd/mm/yr)		Place of Service	Procedures, Services or Supplies	Bill Charges
To	From			
				Total:

Amount Paid:

Balance Due: