American Life Insurance Company
A world leader in insurance and financial services™

CIBC Bank and Trust Company (Cayman) Limited

HEALTH INSURANCE CLAIM FORM

ORIGINAL RECEIPTS/ITEMISED BILLS MUST BE ATTACHED FOR EXPENSES INCURRED UNLESS ASSIGNED

NOTIFICATION AND PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS

TO BE COMPLETED BY INSURED

1. POLICY # CERTIFICATE# ID # TYPE OF PLAN: GROUP ☐ NON-GROUP ☐

2. EMPLOYEE'S/INSURED'S NAME:

PATIENT'S NAME:

DATE OF BIRTH ☐☐☐ GENDER: M ☐ F ☐

NAME OF SPOUSE'S EMPLOYER:

ADDRESS

TELEPHONE #

IS PATIENT'S CONDITION RELATED TO: (a) EMPLOYMENT? YES ☐ NO ☐

(b) AUTO ACCIDENT? YES ☐ NO ☐ (c) OTHER ACCIDENT? YES ☐ NO ☐

IF YES, GIVE DETAILS:

3. Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? YES ☐ NO ☐

If yes, give (a) Name of insurance Company _____

(b) Name of Group or Company Insured under _____

4. If patient is not the Insured, kindly indicate relationship: Spouse ☐ Child ☐ Other ☐

5. Patient's status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐ Full-time Student ☐

I hereby authorise and direct you to pay to _____
all benefits otherwise payable to me as a result of this claim to the extent of bills submitted.

AUTHORISATION: I hereby authorise the doctor to release any information acquired in the course of my examination or treatment

Insured's Signature _____ **Patient's Signature** _____ **Date** _____

6. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER

Patient's Name

Name and address of Doctor/Health Provider

Diagnosis or Nature of illness or Injury (ICD CODE)

1. 2.

3. 4.

GIVE NAME OF REFERRING PHYSICIAN

Is condition due to Pregnancy? Yes ☐ No ☐ If yes, give approximate date of last monthly period.

7. TO BE COMPLETED BY DOCTOR **MEDICAL/SURGICAL TREATMENT**

Date of first symptoms:

Date of first consultation for this condition:

Has patient been previously treated for this conditiion? Yes ☐ No ☐

If yes, give dates: _____

A Date D M Y	B Place of Service (OFFICE/HOME/HOSP.)	C Procedures, Services or Supplies (Explain unusual circumstances)	D Diagnosis(es)	E Charges $	F Co Payment $

FURTHER SERVICES RECOMMENDED	SURGICAL PROCEDURE		
	Date and Type of Operation		
	Name of Surgeon/Assistant Surgeon		
International Medical Group	Name of Anaesthetist		
P.O. Box 30073	**TOTAL**		

Grand Cayman KY1-1201
Cayman Islands
Tel: (345) 945-2881 Fax: (345) 949-4341

Stamp _____ Signature of Doctor / Pharmacist _____ Date

I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED.

AIG

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