DEMERARA MUTUAL

HEALTH CLAIM FORM

ATTACH ORIGINAL RECEIPTS, ITEMISED BILLS, AND ANSWER ALL RELATED QUESTIONS

Notification and proof of claim must be submitted within ninety (90) days

1. EMPLOYER/INDIVIDUAL POLICYHOLDER

POLICY NO.	EMPLOYER/ POLICYHOLDER NAME	ADMINISTRATOR'S SIGNATURE (GROUP ONLY)
CERTIFICATE NO.		DATE

2. TO BE COMPLETED BY EMPLOYEE/INSURED (PLEASE PRINT)

EMPLOYEE'S/ INSURED'S NAME	PATIENT'S NAME	NAME OF SPOUSE'S EMPLOYER
ADDRESS	RELATIONSHIP DATE OF BIRTH	
	IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT ☐ YES ☐ NO b. AUTO ACCIDENT ☐ YES ☐ NO c. OTHER ACCIDENT ☐ YES ☐ NO	
TELEPHONE NO.	IF YES, GIVE DETAILS:	

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 _____

ASSIGNMENT OF INSURANCE BENEFITS (SIGN ONLY FOR DIRECT PAYMENT TO HOSPITAL OR DOCTOR)

I hereby authorise payment directly to the hospital (and physician where applicable) named on the attached Claim Form of the Insurance Benefits payable to me, or so much thereof as may serve to satisfy my indebtedness, or that of my dependant for the treatment and/or services supplied. I understand that I am financially responsible for charges not covered by the Policy.

Date _____ 20 _____ Signature of Insured _____

3. TO BE COMPLETED BY DOCTOR/HEALTH PROVIDER

Patient's Name	Name and Address of Doctor/Health Provider
Diagnosis or Nature of illness or injury 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

4. TO BE COMPLETED BY MEDICAL DOCTOR/SURGEON

Date of first symptoms	Has patient been previously treated for this condition? ☐ YES ☐ NO
Date of first consultation for this condition	If 'YES', give date

A Date D	M	Y	B Place of Service (OFFICE/HOME/HOSP)	C Procedures, Services or Supplies (Explain unusual circumstances)	D Diagnosis 1, 2, 3, 4	E Charges	$

FURTHER SERVICES/DRUGS RECOMMENDED		SURGICAL PROCEDURE	Charges	$
Date				
		Date of Operation		
		Type of Operation		
		Name of Surgeon		
		Name of Assistant Surgeon TOTAL		

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

STAMP _____ SIGNATURE OF DOCTOR/PROVIDER _____ DATE _____

MEDICAL

DEMERARA MUTUAL

LAB/MEDICAL

DENTAL

VISION

TO BE COMPLETED BY HOSPITAL

	Charge $	
No. of days confined ..... ☐ Private ☐ Semi-private ☐ Ward		
Daily hospital charge for patient ($) from..... to		
Operation or delivery room (state type of operation)		
Hospital Services		
Name of Admitting Doctor		

6. TO BE COMPLETED BY LABORATORY/X-RAY DEPARTMENT

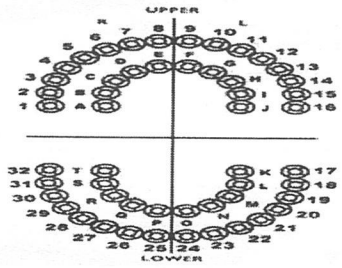
Date	Type(s) of test(s)	Charge	Date	Type(s) of test(s)	Charge

7. TO BE COMPLETED BY DENTIST

NAME OF PATIENT	IF YES, ENTER BRIEF DESCRIPTION AND DATES BELOW	
	If CROWN, was tooth badly broken down? ☐ Yes ☐ No	
ADDRESS	Is treatment as a result of occupational illness or injury? ☐ Yes ☐ No	
	Is treatment as a result of auto accident or other accident? ☐ Yes ☐ No	
TELEPHONE NO.	Are any services covered by another plan? ☐ Yes ☐ No	
EMAIL	Is the treatment for Orthodontics? ☐ Yes ☐ No	

FIRST VISIT DATE DD	MM	YY	PLACE OF TREATMENT - Office ☐ Hosp ☐ Other ☐	X-RAYS OR MODELS ENC? ☐ YES ☐ NO	HOW MANY?

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ Yes ☐ No	IF YES, GIVE DATE OF EXTRACTIONS OF TEETH BEING REPLACED	IF NO, REASON FOR REPLACEMENT AND DATE OF PRIOR PLACEMENT



INDICATE MISSING TOOTH WITH AN 'X'

EXAMINATION AND TREATMENT PLAN, LIST IN ORDER, USE CHARTING SYSTEM SHOWN

Date of Service (dd/mm/yy)	Tooth # or Letter	Surface	Description of Service	Charge $
			☐ PREDETERMINATION ☐ ACTUAL TOTAL	

8. TO BE COMPLETED BY OPTOMETRIST/OPHTHALMOLOGIST

Diagnosis	Date of Service (dd/mm/yy)	Description of Service	Charge $
		(A) EXAMINATION	
		(B) FRAMES	
		(C) LENSES (PLEASE SPECIFY TYPE BELOW)	
		(D) TINTING	

☐ SINGLE ☐ BIFOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES

(a) If 'CONTACT LENSES', were they prescribed for severe corneal astigmatism, corneal, scarring, keratoconous or aphakia ☐ YES ☐ NO

Can visual acuity be improved by up to at least the 20/70 level by spectacle lenses? ☐ YES ☐ NO

Can visual acuity be improved by up to at least the 20/70 level by contact lenses? ☐ YES ☐ NO

(b) Are these PRESCRIPTION SUNGLASSES? ☐ YES ☐ NO

Replacement of LOST or DAMAGED GLASSES? ☐ YES ☐ NO

TOTAL EXPENSES

9. CERTIFICATION – THE FORM MUST BE SIGNED BY DENTIST/OPTOMETRIST/AUTHORISED PERSON

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

STAMP _____ SIGNATURE OF DOCTOR/PROVIDER _____ DATE _____

10. 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 _____