RF&G LIFE INSURANCE COMPANY LTD.

GORDON HOUSE, One Coney Drive, P.O. Box 661, Belize City, Belize
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HEALTH INSURANCE CLAIM FORM

INSTRUCTIONS: *Itemized bills must be attached.*

PART A – THIS SECTION TO BE COMPLETED BY CLAIMANT

CHECK ([) benefits for which you are applying which results from medical expenses incurred by:

☐ Group Ins. Benefits ☐ Individual Ins. Benefits Policy No.

1. Name of Insured
   (First, Middle Initial, Last)
2. Address of Insured
3. Name of Patient
   (First, Middle Initial, Last)
4. Date of Birth
   (Day, Month, Year)
5. Relationship to Insured
6. Nature of Ailment *(If ailment due to injury, state where, why, and how it happened.)*
7. Symptoms first appeared
   (Day, Month, Year)
8. Has patient ever suffered previously from this ailment?
   If "yes," explain. ☐ Yes ☐ No
9. Does ailment result from patients' occupation?
   If "yes," explain ☐ Yes ☐ No
10. Doctors Consulted: Name Address Dates Consulted

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 hospitals or other institutions to furnish full information, including full copies of the records regarding this claim to RFG Insurance Company Ltd.

________________________ Date

________________________ Claimant's Signature

ASSIGNMENT OF INSURANCE BENEFITS) *(Sign only for direst payment to hospital or doctor)*
I hereby authorize payment directly to the hospital, and physician where applicable, named on the attached claim form, of the Insurance Benefits under Policy , 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.

________________________ Date

________________________ Claimant's Signature

DO NOT FORGET TO ATTACH ITEMIZED BILLS

PART B – THIS SECTION MUST BE COMPLETED BY *POLICYHOLDER IF THIS CLAIM IS FOR GROUP INSURANCE

1. Claimant's Name — Effective Date of Claimant's Insurance
2. Dependent's Name (*if claim for dependent*) — Effective Date of Dependent's Insurance
3. Group Policy No.
4. Certificate No.
5. Class of Insurance
6. *Policyholder's Name
7. Was claimant employed at time disability began?
   If "no" explain. ☐ Yes ☐ No
8. Is claimant entitled to Workmen's Compensation benefits and, if so, has claim been made? ☐ Yes ☐ No
9. Do you recommend payment of this claim? ☐ Yes ☐ No

*Employer, employee association or other group to whom the group policy was issued.

____________________ Date

____________________ Signed on behalf of Policyholder by

____________________ Title

ATTENDING PHYSICIAN'S STATEMENT

INSTRUCTIONS: *Print or type answers for questions 1 through 10.*

PATIENT'S NAME AGE

1. Nature of sickness or injury. *(Describe complications, if any.)*

   Is condition due to Pregnancy? ☐ Yes ☐ No
   If yes, what was approximate date of commencement of pregnancy? (Day, Month, Year)

2. When did symptoms first appear or accident happen? (Day, Month, Year)

3. When did patient first consult you for this condition? (Day, Month, Year)

   Was patient referred to you? ☐ Yes ☐ No If yes, by whom?

4. Has patient ever had same or similar condition? ☐ Yes ☐ No
   If yes, state when, describe, and state attending physician.

5. Nature of surgical or obstetrical procedure, if any. (Describe fully)

   Charge for this procedure and date performed. $ (Day, Month, Year)

   Where performed? If in hospital, ☐ in-patient ☐ out-patient

6. Give dates of treatment CHARGE PER CALL

   Office $

   Home $

   Hospital $
   (Admission and Discharge Dates)

7. Is further operative procedure anticipated? ☐ Yes ☐ No

   If yes, explain.

8. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

   If yes, explain.

9. Is patient still under your care for this condition? **Address** **Dates Consulted**

   If discharged, give date, (Day, Month, Year)

10. If fracture or dislocation, state whether complete or incomplete.
    If fracture of long bones, state type and location.
    Was it confirmed by X-ray? ☐ Yes ☐ No

REMARKS

Date

Signature
Physician or Surgeon

Street Address City or Town Country

A member of the Roe Group of Companies