



**RF&G LIFE INSURANCE COMPANY LTD.**

GORDON HOUSE, One Coney Drive, P.O. Box 661, Belize City, Belize  
PH#: 501-223-5734. Fax#: 501-223-6734/223-7345. [www.rfglife.com](http://www.rfglife.com)  
Email: [info@rfglife.com](mailto:info@rfglife.com)

**CLAIM FORM FOR ACCIDENTAL INJURIES**  
**(TO BE COMPLETED BY INSURED/BENEFICIARY)**

**PART A**

NAME OF INSURED: ..... POLICY NO: .....

DATE OF BIRTH: .....

DATE OF ACCIDENT: .....

DETAILS OF ACCIDENT: .....

.....  
.....

DIAGNOSIS: .....

.....was admitted as a patient to .....  
(Name of Insured)

Hospital on ..... and discharged on .....

TYPE OF SERVICE: .....

	<b><u>ITEM</u></b>	<b><u>COST</u></b>
<p><b>AN ITEMISED BREAKDOWN OF DRUGS AND/OR EQUIPMENT SHOULD BE LISTED HERE AND SUPPORTED WITH ORIGINAL RECEIPTS</b></p>	}	

I hereby authorize the release of any Medical information necessary to process this claim.

.....  
Signature

Date:.....

**N.B:** RF&G Life should be notified within 30 days of the claim and proof should be submitted within 90 days of notification.

**PART B**

DATE OF FIRST CONSULTATION: .....

DIAGNOSIS: .....

WAS CONDITION AS A RESULT OF AN ACCIDENT? .....

WAS PATIENT CONFINED TO HOSPITAL? YES  NO

If yes, please state:-

(A) DATE OF ADMITTANCE: .....

(B) DATE OF DISCHARGED: .....

DID PATIENT UNDERGO SURGERY? YES  NO

If yes, please state:-

(A) DATE OF SURGERY: .....

(B) DETAILS OF SURGERY: .....

(C) LIST OTHER SERVICES UTILISED: .....

(D) RESULTS: .....

(E) PROGNOSIS AT DISCHARGE: .....

.....  
SIGNATURE  
ATTENDING PHYSICIAN/  
ADMINISTRATOR OF HOSPITAL

DATE: .....

(KINDLY AFFIX OFFICIAL STAMP)

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