HEALTH INSURANCE CLAIM FORM

Claims must be submitted within 90 days of being incurred and original receipts/itemized bills must be attached.

1. TO BE COMPLETED BY EMPLOYEE / INSURED:

Surname: ______ **First Name:** ______ **Date Of Birth: (d/m/yr):** ______

Address: ______

ID No.: ______ **Telephone Nos.:** ______ ______

Patient's Name ______ **Relationship:** ______ **Date Of Birth: (d/m/yr)** ______

When did symptoms of the ailment first appear? ______

Have you ever had this ailment before? If yes, state when and describe ______

CAUSE OF CONDITION:

Is patient's condition related to: (a) Employment? ☐ Yes ☐ No

(b) Auto Accident? ☐ Yes ☐ No

(c) Other Accident? ☐ Yes ☐ No

Details: ______

If Yes, State Name of Employer's Insurer: ______

CO-ORDINATION OF BENEFITS:

Is patient covered by any other plans which provide benefits for this injury or sickness?

☐ Yes ☐ No

If "Yes", give (a) Name Of Insurance Company ______

(b) Insured's Name ______

(c) Name of Group or Company Insured Under ______

AUTHORIZATION:

I/we hereby certify that the foregoing answers are true and correct to the best of my/our knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full detailed information (including full copies of their records) regarding this claim

Insured's Signature: ______

Spouse's Signature: ______

Date: ______

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and direct you to pay to ______

______

all benefits due to me or my covered dependant (s) as a result of this claim.

I understand that I am Financially responsible for charges not covered by the Policy.

Insured's Signature: ______

Date: ______

2. TO BE COMPLETED BY EMPLOYER / POLICYHOLDER:

Policy Holder: ______ Policy No: ______ Employee Certificate No: ______ Effective Date: ______

Has employee made claim for Workmen's Compensation? ☐ Yes ☐ No Is he/she entitled to such benefits? ☐ Yes ☐ No

Company's Stamp: ______ Administrator's Signature: ______ Date: ______

3. TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:

Patient's Name: ______

Date Of Birth: (d/m/yr) ______

Diagnosis	Date of Service d/m/yr	Description of Service	Change $

☐ SINGLE ☐ BI-FOCAL ☐ MULTI-FOCAL ☐ LENTICULAR ☐ CONTACT LENSES ☐ SUNGLASSES TOTAL ______

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

______ STAMP

______ SIGNATURE OF OPTICIAN/OPHTHALMOLGIST/OPTOMETRIST

______ DATE

American Life Insurance Company

1. TO BE COMPLETED BY DOCTOR / HEALTH PROVIDER:

Patient's Name: ______________________

Date Of Birth: (d/m/yr) ______________________

Date of Visit or Service	Diagnosis/ICD Code	Visit fee	Type of Visit	Service Rendered (drugs, injections, test, supplies)	Cost	Further Services Recommended

Date of first symptom: ______________________ Has patient been previously treated for this condition? ☐ Yes ☐ No

Date of first consultation for this condition: ______________________ If Yes, give date: ______________________

Was patient referred? If "Yes" state name of referring doctor: ______________________

SURGICAL PROCEDURES Date of Surgery: Surgeon's Fee $

Describe Procedure(s) Performed: Asst. Surgeon's Fee $

Anaesthesist's Fee $

MATERNITY Date Pregnancy Commenced/LMP: Date of Delivery or Termination:

Type of Delivery: Obstetrical Fee $

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

STAMP SIGNATURE OF DOCTOR/HEALTH PROVIDER DATE

5. TO BE COMPLETED BY DENTIST:

Patient's Name: ______________________

Date Of Birth: (d/m/yr) ______________________

DENTIST ______________________ TEL No: ____________

(a) Is treatment a result of occupational illness or injury? ☐ Yes ☐ No (Details if yes)

(b) Is treatment a result of auto accident? ☐ Yes ☐ No ______________________

(c) Other accident? ☐ Yes ☐ No ______________________

LABIAL
LINGUAL
UPPER
RIGHT
LEFT
PRIMARY
PERMANENT
LOWER
LINGUAL
LABIAL

LIST OF SERVICES (USE CHARTING SYSTEM SHOWN)

Date of Service (d/m/yr)	Tooth# or Letter	Surface(s)	Description of Service	Charge $
			TOTAL	

ORTHODONTIC TREATMENT

(a) Date of first appliance: ____________

(b) Date of last appliance: ____________

(c) Treatment period (no. of months): ____________

(d) Monthly treatment fee: ____________

(e) Total fee: ____________

CROWNS

(a) Is this an initial placement? ____________

(b) Reason: ____________

(c) Date of prior placement: ____________

(d) Was root canal treatment performed? ____________

INITIAL DENTURES OR BRIDGES

(a) Is this an initial placement? ____________

(b) Date of prior placement: ____________

(c) Reason for replacement: ____________

(d) Were teeth extracted for the appliance? ____________

(e) Date of extraction: ____________

(f) Indicate teeth replaced by this appliance: ____________

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

STAMP SIGNATURE OF DENTIST DATE