



**Health Insurance**

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.  
Please submit completed form via Email to BS\_claims\_admin@cgcoralisle.com or via Fax to 242 326 8189.

**PART 1** To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured \_\_\_\_\_

Group Policy No. \_\_\_\_\_ Certificate/Employee No. \_\_\_\_\_

Name of Employer \_\_\_\_\_ Transit No. \_\_\_\_\_

Full Name of Patient \_\_\_\_\_

Patient's Mailing Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

Patient's Date of Birth (DD/MM/YY) \_\_\_\_\_ Patient's Gender  Male  Female

Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

If the Patient has any other Health Insurance coverage, provide name of policy holder and number \_\_\_\_\_

Was sickness/injury related to  Patient's employment  Traffic Accident  Pregnancy  Other (give details below)

**DECLARATION:**

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions to furnish full information, including full copies of records, regarding this claim to Atlantic Medical Insurance Limited.

Patient's or Authorised Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS** (sign only if requesting direct payment to hospital or doctor):

I hereby authorise payment directly to the hospital, and physician where applicable, named on the attached claim form, other than 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 the charges not covered by the Policy.

Patient's or Authorised Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART 2** To be completed by the ATTENDING PHYSICIAN

**A separate claim form or itemized account should be submitted by each attending physician.**

Date of illness (first symptom), injury (accident) or pregnancy (last monthly period) (DD/MM/YY) \_\_\_\_\_

Date patient first consulted you for this condition (DD/MM/YY) \_\_\_\_\_

Has patient ever had same or similar symptoms?  Yes  No

Name of referring physician or other source \_\_\_\_\_

Hospitalisation dates related to current services (if applicable) Admitted (DD/MM/YY) \_\_\_\_\_ Discharged (DD/MM/YY) \_\_\_\_\_

Name and address of facility where services rendered (if other than home or office) \_\_\_\_\_

Was laboratory work performed outside your office?  Yes  No

Was the following operation(s) to correct a condition detrimental to the patient's health?  Yes  No



**Health Insurance**

Diagnosis or Nature of Illness/Injury \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE OF SERVICE	PLACE OF SERVICE*	PROCEDURE CODE	FULL DESCRIPTION OF TREATMENT FOR EACH DATE GIVEN	DIAGNOSIS CODE	CHARGES	DAYS/UNITS	TYPE OF SERVICE*

**\*PLACE OF SERVICE**

- 1 - IH = Inpatient Hospital
- 2 - OH = Outpatient Hospital
- 3 - O = Doctor's Office
- 4 - H = Patient's Home
- 5 - IL = Independent Laboratory

**\*TYPE OF SERVICE**

- 1 = Medical Care
- 2 = Surgery
- 3 = Consultation
- 4 = Diagnostic Laboratory
- 5 = Anaesthesia (Duration Required)
- 6 = Assistance at Surgery
- 7 = Other Medical Service

Patient's Account Number	Total Charges	Amount Paid	Balance

**DECLARATION OF PHYSICIAN OR SUPPLIER:**

I certify that the statements on this form are true and complete to the best of my knowledge.

Full Name \_\_\_\_\_ Telephone \_\_\_\_\_

Mailing Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Atlantic Medical Insurance Limited**

Atlantic House, 2nd Terrace & Collins Avenue | PO Box SS-5915, Nassau, Bahamas | Tel 242 326 8191 | Fax 242 326 8189  
 Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442  
 www.CGCoralisle.com

Health Insurance and Employee Benefits

**INSURANCE | HEALTH | PENSIONS | LIFE**

A member of Coralisle Group Ltd.