CLICO CAYMAN LTD.

HEALTH INSURANCE CLAIM FORM

Please attach origi.

ENROLLEE AND PATIENT INFORMATION

ENROLLEE'S IDENTIFICATION NUMBER:	POLICY/PLAN NUMBER:	POLICYOWNER/ PLAN SPONSOR:
PATIENT'S NAME (Last, First, Middle):	PATIENT'S RELATION TO ENROLLEE: [ ] Self [ ] Spouse [ ] Child [ ] Other	ENROLLEE'S NAME (Last, First, Middle):
PATIENT'S MAILING ADDRESS (P O Box):	PATIENT'S STATUS: [ ] Single [ ] Married [ ] Other [ ] Employed [ ] Student [ ] Other	ENROLLEE'S MAILING ADDRESS (P O Box):
PATIENT'S STREET ADDRESS:	PATIENT'S CONDITION RELATED TO: [ ] Employment, date: [ ] Accident, date: [ ] Other emergency, date: [ ] Pregnancy, LMP: [ ] Substance abuse, date: [ ] Other, date:	ENROLLEE'S STREET ADDRESS:
PATIENT'S PHONE & FAX NUMBERS:		ENROLLEE'S PHONE & FAX NUMBERS:

PATIENT'S AUTHORISATION

I authorise the Insurance Company to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.

Signature _____ Date _____

PAYMENT ASSIGNMENT

I authorise the Insurance Company to pay the proceeds of this claim to the undersigned Medical Services Provider.

Signature _____ Date _____

MEDICAL PROVIDER INFORMATION

DATE OF FIRST SYMPTOM OR LMP:	IF PATIENT HAD SUFFERED SAME OR SIMILAR ILLNESS BEFORE, GIVE DATE(S):	IF PATIENT WAS UNABLE TO WORK DUE TO THIS ILLNESS, GIVE DATE(S):
NAME AND ADDRESS OF REFERRING OR PREVIOUS PHYSICIAN, OR OTHER SOURCE:		IF PATIENT WAS HOSPITALISED FOR THIS ILLNESS, GIVE DATE(S
DATE YOU FIRST TREATED PATIENT FOR THIS ILLNESS:	WAS OUTPATIENT DIAGNOSTIC SERVICES ORDERED, OR MEDICATION PRESCRIBED? [ ] Yes [ ] No	NATURE OF ACCIDENT, IF APPLICABLE:

DIAGNOSIS, ILLNESS OR INJURY*		TREATMENT SERVICES*				
CODE	DESCRIPTION	DATE(S) From	DATE(S) To	CODE	DESCRIPTION	CHARGE CI$

** If required, additional information may be detailed on the reverse side of this form.*

PATIENT ACCOUNT NO:	ACCEPT ASSIGNMENT? [ ] Yes [ ] No	TOTAL CHARGE: CI$	AMOUNT PAID: CI$	BALANCE DUE: CI$

I certify that the information furnished above is true and correct to the best of my knowledge.

PROVIDER NAME:	PROVIDER TELEPHONE NUMBER: Tel:	PROVIDER REGISTRATION NUMBER:
	PROVIDER'S SIGNATURE:	DATE: