DEMERARA MUTUAL

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MEDICAL CLAIM FORM

PRINCIPAL'S STATEMENT

(Note ALL questions MUST be answered for every claim.
NA = Not Applicable)

Principal's No: _____ Group Name:_____ Group No: _____ Claim No: _____

1. Principal's Name _____ Date of Birth _____ Sex: Female ☐ Male ☐
2. Name of Patient _____ Date of Birth _____ Sex: Female ☐ Male ☐
3. Relationship of Patient to Principal: Self ☐ Spouse ☐ Child ☐ Other ☐ (Explain) _____
4. Name of Illness or Condition _____ Attending Physician _____
5. When did symptoms of this illness first occur? D_____/M_____Y_____ NA ☐
6. Was treatment necessary because you were injured or poisoned? Yes ☐ No ☐
7. If you were injured or poisoned, state the **Date**, **Time** and **How** the incident occurred. _____ NA ☐
8. Did you voluntarily participate in an activity targeted for abuse or endangered? Yes ☐ No ☐
9. Have you ever been identified as having Hypertension? Yes ☐ No ☐
10. If you have been identified as having Hypertension, please give year of diagnosis._____
11. Have you ever been identified as having Diabetes? Yes ☐ No ☐
12. If you have been identified as having Diabetes, please give year of diagnosis._____
13. Are you entitled to Workmen Compensation or coverage under any other medical plan? Yes ☐ No ☐
14. If you gave 'Yes' to question 13 above, give name of Company. _____ _____ NA ☐
15. If you gave 'Yes' question 13 above, have you made any claim for the relevant benefits? Yes ☐ No ☐
16. Check all your receipts submitted for this claim and in the spaces provided below please write your total expenses for each category.

A) No. of Days Supply of Prescription Drugs? _____ Days Cost$ _____ B) Days Visited Doctor? _____Days $_____

C) No. of Days Supply of Non-Prescription Drugs? _____Days Cost$_____ D) Days Visited Specialist? _____ Days $_____

E) No. of Days Supply of Room & Board? _____ Days Cost$_____ F) Hospital Services? $_____

G) Surgeon's Fee? $_____ H) Anaesthetist's Fee? $_____ I) Diagnostics?(X-Rays, Labs, Scans, etc) $_____

J) _____? $_____ K)_____? $_____ _____L) Discount? $_____

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 their records) regarding this claim to **Demerara Mutual Life**. I also understand that only original documents are valid in support of my claim and that once submitted, all documents associated with the expense and other relevant circumstances associated with the loss, becomes the property of the Company. I agree to reimburse **Demerara Mutual Life** to the extent of the amount paid on this claim under any Occupational Policy Provision in the event benefits are provided under any Workmen's Compensation Law or similar Legislation. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Principal's Signature X_____ Patient's Signature (if over 18yrs) X_____

EMPLOYER'S STATEMENT

Employee's Occupation_____Date Employed_____

AM

If Patient is Employee state the last day of work_____Hour_____PM

Has the employee returned to work? Yes ☐ When?_____No ☐ When expected?_____

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

Employer _____By_____Date_____20_____

APPLICATION FOR ASSIGNMENT OF COVERAGE BENEFITS **NA ☐**

I hereby authorise Demerara Mutual to pay to _____ whatever benefits to which I may be entitled with respect to the services rendered to the named patient from _____20 _____ to _____20 _____

All charges that are not covered by the Medical Plan shall be borne by me.

_____ X_____ NA ☐

Date Principal's Signature

FOR OFFICIAL USE ONLY

_____ _____ X_____ _____

Date Received Recipient's Name (PRINT) Group Administrator's Signature Title

Please ensure that your doctor completes all questions on the reverse side, especially the section named "*MEDICAL FACTORS*'. This can eliminate delays, inconvenience and the expense of obtaining reports.

Please complete this Form and give to your patient

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____ Name of Principal: _____

Address:_____

DOCTOR'S VISIT	DATE OF VISIT OR SERVICE	DIAGNOSIS (DESCRIBE COMPLICATIONS IF ANY)	TYPE OF VISIT (OFFICE, HOME OR HOSPITAL)	VISIT FEE	NAME OF DRUG(S) PRESCRIBED OR INJECTED	QTY.	COST (IF SUPPLIED)	OTHER SERVICE RENDERED (SPECIFY)	COST $	FURTHER SERVICE RECOMMENDED	DOCTOR'S SIGNATURE ↓

SURGICAL OPERATION

Please describe procedure(s) performed:

Date of Surgery: _____/_____ Surgeon's Fee: $_____

Anaesthetist's Fee: $_____

MATERNITY

Date of Conception: _____/_____ Date of Delivery or Termination: _____/_____ Obstetrician Fee: $

_____

Did Artificial Insemination, Fertility Drugs, Hormone Treatment or other means induce pregnancy where medical or other assistance was used? Yes ☐ No ☐

Type of delivery/ Procedure? Normal ☐ Caesarean Section ☐ Miscarriage ☐ D&C ☐ Other ☐

_____

MEDICAL FACTORS (Please complete, date and sign this section to ensure that patient's claim is not delayed.)

A Has the patient been identified as suffering from: - (i) **Hypertension**? Yes ☐ No ☐ (ii) **Diabetes**? Yes ☐ No ☐

B Please identify any factors that my have aggravated the illness or condition or hindered recovery? _____

C Please state what, in your opinion, is the underlying cause of this illness or condition? _____

_____

D Please use the Class Numbering system below to classify the illness or condition by describing its underlying cause. Encircle all relevant Class Numberings including only the descriptions that apply. *(Example: A contagious disease, Gonorrhea, has an incubation less than 3 months, i.e. Class 2; it is also a venereal disease, i.e., Class 6; and it is also generally accepted as curable, i.e. Class 10. tough it may affect organs, it is NOT classified with organs, i.e., Class 7)*

Class No.	Description	Class No.	Description	Class No.	Description
1.	Physical Injury from external force: Poison	7.	Chronic; Circulatory; Degenerative; Organ; Gland; Malignant	11.	Generally Accepted as **incurable**
2.	Infectious: Contagious; Parasitic (incubation less than 3 months)	8.	Psychiatric; Nervous System; Syndrome	12.	Allergy; Immune Deficiency
4.	Infections; Contagious; Parasitic (incubation greater than 3 months)	9.	Tumor; Cancer; Abnormal Growth; Concretions	13.	Tobacco; Alcohol; Substance Abuse
6.	Maternity; Congenital; Abortion; Venereal Disease	10.	Generally accepted as curable	15.	Nuclear radiation; Of Biological or Chemical Arsenal

Additional Remarks: Date:_____ Doctor's Signature X_____