Generali Worldwide

Health Insurance Claim Form

GENERALI

PLEASE COMPLETE THIS FORM USING BLOCK CAPITALS

1. Patient’s Name (First name, middle initial and last):

2. Patient Birthdate: M M D D Y Y

3. Insured's Name (First name, middle initial and last):

4. Patient’s Full Address & Phone Number:

5. Patient's Sex: Male ☐ Female ☐

6. Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

7. Is dependent a full time student? Yes ☐ No ☐
If Yes, name and address of college:

8. Insured's Group and ID Numbers:

9. Does patient have any other health insurance? Yes ☐ No ☐
If Yes, give name of insurance company, address, policy and name of insured:

10. Was condition related to: **a)** Patient's employment Yes ☐ No ☐

b) An accident Yes ☐ No ☐

11. If an accident, give date and brief details:

GW (UW) HC Bah HI Claim Form 12'18

12. AUTHORISATION I certify that the information furnished by me in support of this claim is true and correct. I hereby authorise any insurance company, organisation, employer, hospital, physician, surgeon, pharmacist, educational institution or other person to release any information requested with respect to this claim. A photostatic copy or other reproduction of this release will be as valid as the original.

Signature of patient: Date: MM DD YY

13. ASSIGNMENT OF BENEFITS TO PHYSICIAN I hereby authorise payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable customary charge for those services.

Signature of insured: Date: MM DD YY

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of illness (first symptom), injury or pregnancy (LMP): MM DD YY

15. Date first consulted for this condition: MM DD YY

16. Has this patient ever had same or similar symptoms? Yes ☐ No ☐

17. Date patient able to return to work: MM DD YY

18. Type of disability: Partial ☐ Total ☐

Disabled from: MM DD YY Disabled to: MM DD YY

19. Hospitalised from: MM DD YY Hospitalised to: MM DD YY

20. Name and address of referring physician:

21. Name and address of facility where services rendered:

22. Please list any other insurance companies with which you have filed this claim:

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PHYSICIAN OR SUPPLIER INFORMATION (Continued)

23. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to number 1,2,3, etc. or DX code.

1.

2.

3.

4.

24.

Date of Service	Place of Service	Procedure Code	Description of Procedure Service or Supply	Diagnosis Code	Charges

25. Signature of Physician or Supplier:

Date: MM DD YY

26. Name, Address of Physician or Supplier:

27. Total Charge:

28. Paid:

29. Due:

30. Patient's Account No:

31. Your ID No:

32. Accept Assignment: Yes ☐ No ☐

GW (UW) HC Bah HI Claim Form 12'18

PRESCRIPTION DRUG EXPENSES

1. Please type or print and include all information indicated.
2. A separate copy must be made for each family member for whom claim is made.
3. ORIGINAL RECEIPTS OF EACH DRUG EXPENSE MUST BE ATTACHED.

EXPENSE ONE

Nature of illness or injury:

Name of Drug:

Prescription Number:

Date of Purchase: M M D D Y Y

Account Charged:

Nature of Pharmacy:

Prescribing Physician:

EXPENSE TWO

Nature of illness or injury:

Name of Drug:

Prescription Number:

Date of Purchase: M M D D Y Y

Account Charged:

Nature of Pharmacy:

Prescribing Physician:

EXPENSE THREE

Nature of illness or injury:

Name of Drug:

Prescription Number:

Date of Purchase: M M D D Y Y

Account Charged:

Nature of Pharmacy:

Prescribing Physician:

EXPENSE FOUR

Nature of illness or injury:

Name of Drug:

Prescription Number:

Date of Purchase: M M D D Y Y

Account Charged:

Nature of Pharmacy:

Prescribing Physician:

EXPENSE FIVE

Nature of illness or injury:

Name of Drug:

Prescription Number:

Date of Purchase: M M D D Y Y

Account Charged:

Nature of Pharmacy:

Prescribing Physician:

GW (UW) HC Bah HI Claim Form 12'18

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Regulated in Guernsey as a licensed insurer by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002 (as amended).
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