Generali Worldwide
Group Health Insurance – Health Insurance Claim Form

Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

Instructions for Submitting a Claim

1. Complete this form and attach all requested documents, including fully itemized medical bill(s) or in the event you have paid any eligible medical expenses, receipt of payment.
2. Sections A, C and D – must be completed by the Insured (Employee).
3. Section B – must be completed by the Provider of Services.

If you have a fully itemized medical bill, the Provider does not need to complete Section B, but all documentation from the provider must include:

- Patient Name
- Date of Service
- Diagnosis/ Nature of Illness
- Procedures performed (office visit, lab, surgery, etc.)
- Billed Charges
- Currency for each Service Provided

4. A separate claim form must be completed for each family member who is making a claim
5. All documentation and related correspondence must be sent to either:

Generali Worldwide Cayman Service Centre
P.O. Box 10212
Grand Cayman, KY1-1002, Cayman Islands
Phone: 345 747 2000
Fax: 345 945 7288
E-mail: caymanservice@generali-health.com

Generali Worldwide Global Service Centre
P.O. Box 306
266 Elmwood Avenue
Buffalo, NY 14222
Phone: +1 905 669 7353
Toll Free: +1 877 618 7016
Fax: +1 905 762 5194
E-mail: globalservice@generalihealth.com

SECTION A – INSURANCE INFORMATION – To be completed by Member

1 **a)** Group Name:

b) Group Number:

c) Policy ID Number:

2. Patient's Name (First Name, Middle Initial, Last Name):

3. Patient's Birth Date: M M D D Y Y (MM/DD/YY) Sex: Male ☐ Female ☐

4. Insured's Name (First Name, Middle Initial, Last Name):

5. Patient's Address (No., Street):

City: Island:

Zip Code: Telephone (Include Area Code):

6. Patient's Relationship to Insured:

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7. Insured's Address (No., Street):

City: Island:

Zip Code: Telephone (Include Area Code):

8. Patient Status: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

9. Insured's Policy Group or FECA No.:

a) Insured's Date of Birth: M M D D Y Y (MM/DD/YY) Sex: Male ☐ Female ☐

b) Employer's Name or School Name:

c) Insurance Plan Name or Program Name: **Generali Worldwide**

d) Is the patient covered by another health benefit plan? Yes ☐ No ☐ If Yes, Complete Section 10 – This section refers to the policy holder of the other health benefit plan for coordination of benefits). If No, Complete Section 11.

10. Name of Insured:

a) Group No. and/or Policy ID No. on other health benefit plan:

b) Effective Date of Coverage: M M D D Y Y (MM/DD/YY)

c) Date of Birth: M M D D Y Y (MM/DD/YY) Sex: Male ☐ Female ☐

d) Is the Patient the: Insured ☐ Dependant ☐

e) Employer's Name or School Name:

f) Insurance Plan Name or Program Name and Address:

11. Patient's condition related to:

a) Employment? (Current Or Previous): Yes ☐ No ☐

b) Auto Accident? Yes ☐ No ☐

Place of Accident:

c) Other Accident? Yes ☐ No ☐ Date of Incident: M M D D Y Y (MM/DD/YY)

Please provide a brief description of how the injury or accident occurred:

12. a) Date illness/ symptom first appeared? M M D D Y Y (MM/DD/YY)

b) Date illness/ symptom first treated? M M D D Y Y (MM/DD/YY)

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SECTION B - SUMMARY OF SERVICES - To be completed by the Provider IF Member does not have an itemized bill detailing services rendered & provider information

14. Date Of Current Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP): M M D D Y Y (MM/DD/YY)

15. If patient has had same or similar illness, give first date: M M D D Y Y (MM/DD/YY)

16. Dates unable to work in current occupation: From M M D D Y Y To M M D D Y Y (MM/DD/YY)

17. Name of referring physician or other source:

a) ID No. of Referring Physician:

18. Hospitalization dates related to current services: From M M D D Y Y To M M D D Y Y (MM/DD/YY)

19. Reserved for local use:

20. Outside Labs? Yes ☐ No ☐ Charges: Indicate Currency:

21. Diagnosis or Nature of Illness or Injury (relate items 1, 2, 3 or 4 to item 23b by line):

1.

2.

3.

4.

22. Prior Authorization Number:

23. Service History:

A		B
Date(s) Of Service		Type of Service
From	To	

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C	D	E	F	
Procedures, Services or Supplies				
CPT/ HCPCS	MOD	DX	Procedure	

G	H	I	J	K
Days or Units	RPSDT Family Plan	EMG	COB	$ Charges

24. Federal Tax ID number: SSN EIN

25. Patient's Account No.:

26. Accepts assignment? Yes ☐ No ☐

27. Total charge:

28. Amount paid:

29. Balance due:

30. Signature of physician or supplier including degree or credentials:

Signed: Date: M M D D Y Y (MM/DD/YY)

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31. Name and address of facility where services were rendered (if other than home or office):

32. Suppliers billing name, address, zip code & phone number:

PIN# Grp#

SECTION C – ASSIGNMENT OF BENEFITS – To be completed by Member

This section identifies who should be reimbursed for the claim submitted. Please select only one option (Provider or Insured).

☐ Provider

☐ Insured – If payment is to be made to the Insured, please complete the section below:

In what currency would you like to be reimbursed?

☐ Same currency as the bill (claim)

☐ Policy currency (US Dollars)

☐ Other, please indicate

If no selection is made, the reimbursement payment will automatically be issued in the currency of the Insured's location.

Would you like to receive your reimbursement by: Cheque ☐ Wire Transfer* ☐

Name as it should appear on the cheque or wire transfer:

Please add approximately ten days to the processing time if you have requested a wire transfer or have requested to be paid in a currency other than US dollars.

*To receive a wire transfer, you must submit a Wire Transfer Authorization form and submit it along with the claim form. Failure to supply requested documentation will delay the processing of your claim. Certain banking institutions may charge a fee when accepting a wire transfer. This fee is your responsibility.

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SECTION D – AUTHORIZATION – To be completed by Member

USING YOUR PERSONAL INFORMATION: The personal information that you supply to us and to any third parties acting on our behalf may be used for a variety of reasons. For example: to administer your claim; to arrange for medical treatment; to calculate the premium payable by the policyholder; to complete returns required by our regulators; to deal with any complaints and to enable us to obtain payment from our reinsurers. We are also required to review the information that we hold for the purposes of crime prevention and compliance with international sanctions. We may share your information with, and obtain information about you from, other companies who are involved in the provision of services relating to the insurance policy. For example: companies providing administration, claims and medical services on our behalf. If you require any further information please contact: The Data Protection Officer, Assicurazioni Generali S.p.A., 100 Leman Street, London E1 8AJ, UK.

CONSENT TO USE PERSONAL INFORMATION: I consent to the processing of my personal information (including any medical information relating to myself or my dependents) as set out above.

MEDICAL RECORDS: I authorise any insurance company, organization, employer, hospital, physician, surgeon, pharmacist, laboratory and other provider of healthcare or medical services to release any information requested with respect to this claim relating to myself and my dependents. A photostatic copy or other reproduction of this release will be as valid as the original.

DECLARATION OF TRUTH: I declare that to the best of my knowledge and belief the statements made on this form are true and complete. I understand that if the statements made on this form are not true and complete or if this claim is found to be fraudulent my claim may be denied and I may be excluded from the cover provided by the insurance policy.

PAYMENT AUTHORIZATION: I hereby authorize payment to be made to the insured or provider as indicated in Section C.

Signature of Insured Person (Parent or Guardian if claim is for a minor):

Date: M M D D Y Y (MM/DD/YY)

WHAT TO EXPECT DURING THE CLAIMS PROCESS

It is our goal to process eligible claims in a prompt manner, however, due to variations in health billing systems, you may receive invoices or remainder notices directly from the health provider. Should you receive any such correspondence or if you have paid invoices directly, please forward these to the Generali Worldwide Global Service Centre.

In order to expedite your claim, please return the completed claim form and all supporting documents as soon as possible. Failure to complete the claim form and attach requested documents will delay the processing of your claim. Please keep a copy of all submitted correspondence for your records.

To view your information online, please login to https://services.hi-techhealth.com/GWW/pages/signon.shtml and enter in your username and password. If you are logging in for the first time, your default Username is your Member ID number and your default Password is your date of birth in an eight digit format (MMDDYYYY).

Office: Generali Worldwide, Second Floor, Bougainvillea Way, Grand Pavilion Commercial Center, 802 West Bay Road.
Mailing address: Generali Worldwide, PO Box 10212, Grand Cayman, KY1-1002, Cayman Islands.
Regulated in the Cayman Islands as a licensed insurer by the Cayman Islands Monetary Authority.
Incorporated in Guernsey under Company Registration No. 27151.
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