GUARDIAN LIFE OF THE CARIBBEAN LIMITED

Looking After Life

A Member of the Guardian Holdings Group

U.W.I. FULL TIME STUDENTS MEDICAL INSURANCE CLAIM FORM (complete for every claim)

U.W.I. Student I.D. No.:.....

1. Student's Name..... Tel. Contact.:.....
   SURNAME MIDDLE INITIAL FIRST NAME
2. Faculty/School..... Date of Birth.....
3. Name of Attending Physician.....
4. When did symptoms of this ailment first appear or accident happen? .....
5. Have you ever had this ailment before?..... If "YES", state when and describe.....
   .....
6. Did your injury or sickness arise out of your enrolment? ..... If "YES", state when and describe.....
   .....
7. Are you covered by any other GROUP Insurance Plan providing benefits for this injury or sickness?.....
   If "YES" give
   (a) Name of Insurance Company.....
   (b) Name of Group or Company insured under .....
   (c) Name of Insured Person.....
8. Statements/bills for the following expenses are attached in support of my claim:

Hospitalization	X-ray	Drugs	Specialist Consultation
Surgery	Lab Test	Injections	Other Treatment Service

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 THE INSURANCE COMPANY.

Date..... Student's Signature.....
mm/dd/yy

ASSIGNMENT OF HOSPITALIZATON OR SURGICAL BENEFITS

I hereby authorize the Insurance Company to pay to .....
.....
whatever hospitalization/surgical benefits to which I may be entitled under Group Policy No. .....
with respect to the hospital confinement of/services rendered to the named patient from ..... to .....
mm/dd/yy mm/dd/yy

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

Date..... Signature of Student.....
mm/dd/yy

U.W.I. PLAN ADMINISTRATOR

1. Group Policy No ..... Certificate No.....
2. Faculty/School..... Date Student became insured.....

Date..... Signature of U.W.I. Plan Administrator .....
mm/dd/yy

THIS FORM IS TO BE COMPLETED BY THE STUDENT, THE PLAN ADMINISTRATOR AND HIS PHYSICIAN. Be certain ALL questions are answered and ALL information requested is furnished. The attending Physician's Statement on the reverse side MUST be completed and furnished.

FOR OFFICIAL USE ONLY

Claim No..... Date received ..... Date Paid.....
mm/dd/yy mm/dd/yy

Amount Paid..... Adjuster's Initial .....

ATTENDING PHYSICIAN'S STATEMENT

(Please complete this form and give to your patient)

General

Name of Student

Address:

Age:

Doctor's Visits

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	Quantity	Cost (if supplied)	Other Service Rendered (specify)	Cost $	Further Service Recommended	Doctor's Signature

Surgical Operations

Describe Procedure(s) performed:	Date of Surgery:	Surgeon's Fee: $ Anaesthetist's Fee: $

Remarks