



INSURANCE CLAIM FORM

Sagicor Allnation Insurance Company Claim Form

Claim Form, original itemized bills and all related correspondence must be mailed to:

Sagicor Allnation Insurance Company
c/o Sagicor International Management Svcs.
4010 W. Boy Scout Blvd., Suite 800
Tampa, Florida 33607-5735 USA

Toll Free: (800) 342-0719
Telephone: (813) 286-2222
Fax: (813) 287-7420

Insurance products provided by
Sagicor Allnation Insurance Company
<http://www.allnation.com>

SECTIONS A, B, C, D TO BE COMPLETED BY INSURED - Please be sure to provide all requested information and include original itemized bills (invoices) from the healthcare provider. Photocopies of documents are not acceptable.

A. INSURED (SUBSCRIBER) INFORMATION

1. Insured's Name (Last, First, MI)		2. Alias Name(s)	
3. Mailing Address			
4. E-Mail Address		5. Home Telephone Number	
6. Policy Number	7. Work Telephone Number	8. Facsimile Number	

B. PATIENT INFORMATION

9. Patient's Name (Last, First, MI)		10. Alias Name(s)	
11. Patient's Date of Birth (MM/DD/YY)		12. Patient's Relationship to Insured	
13. Describe Illness or Injury <i>(If maternity, please complete and include maternity form)</i>		14. Date of Illness (first symptoms) or Accident (MM/DD/YY)	
15. Do you or any member of your immediate family have any other insurance that may cover all or part of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. If yes (to #16), give insurance company name, address & policy # and Effective Date.	

C. ASSIGNMENT OF BENEFITS

17. Assignment: Please pay provider directly to the address indicated on the attached original provider invoice. <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Insured's Signature	19. Date Signed

D. AUTHORIZATION TO RELEASE INFORMATION

I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

20. Insured's Signature	21. Date Signed
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CLAIMS REIMBURSEMENT INFORMATION - Claims are reimbursed in U.S. Dollars by check.

E. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

