BAF FINANCIAL INSURANCE (BAHAMAS) LIMITED

GROUP INSURANCE HEALTH CLAIM FORM

To be completed by the Treating Physician
(PLEASE USE BLOCK LETTERS)

BAF TIN #: 100239418

1. Patient's Name (first, middle initial, last)	2. Patient's Birth date **MM/DD/YY**	3. Insured's Name (first, middle initial, last)
4. Patient's full address & phone number	5. patient's sex: Male Female	6. Insured's BAF Group/ID number
7. Relationship to insured self spouse child other	8. Is dependent a full-time student? Yes No If YES name and address of school	9. Does patient have 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 B. Auto Accident Pregnancy ☐ Substance abuse ☐ Other		11. Please provide date and brief details.

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

SIGNATURE OF THE PATIENT: _____ **DATE:** _____

13. **ASSIGNMENT OF BENEFITS TO PHYSICIAN** I hereby authorize payment directly to the undersigned **Medical Services Provider**.

SIGNATURE OF INSURED: **DATE:**

PHYSICIAN OR SUPPLIER

14. Date first symptom injury or pregnancy (LMP)	15. Date patient first consulted you for this condition:	16. Has patient ever had same or similar symptoms prior to this visit?
17. If Patient was unable to work due to this illness give date(s):	18. If patient was hospitalized for this illness give date(s):	

19. Name and address of referring physician	20. Name and address of facility where services rendered

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

Diagnosis or nature of illness or injury.

1. _____ 2. _____ 3. _____ 4. _____

Date of Service **MM/DD/YYYY**	Place of Service	Procedure Code	Description of Procedure Service	Diagnosis Code	Charges

I CERTIFY THAT THE INFORMATION FURNISHED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Physician or Supplies, Date (DD/MM/YY)	Name, Address of Physician or supplier	Total Charge	Paid	Due
Patient's Account #		Your ID#	Accept Assignment? Yes No	

ACKNOWLEDGEMENT

Any person who knowingly and with intent to defraud or deceive any insurance company by (1) filing an application for insurance or a claim containing any materially false information or (2) concealing or misleading information concerning any material fact, commits a fraudulent insurance act that may be considered a crime under applicable law. I certify that all of the information supplied in this Claim Form is complete, true, and accurate.

AUTHORIZATION FOR PROVIDERS TO RELEASE HEALTH INFORMATION

B A F Financial & Insurance (Bahamas) Ltd and its subsidiaries and affiliates (collectively "BAF") may need to use my or my dependents' medical records, prescription medication records, treatment records and plans, or any other medical or pharmaceutical information which may be related to this claim. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), or any other organization or person having any such medical information to disclose such information to BAF or its Business Associates to evaluate this claim for insurance benefits.

I understand that BAF's ability to properly adjudicate my claim is dependent upon the receipt of all necessary health information. As such, my refusal to provide this authorization may result in the denial of this claim.

I understand that:

- I am entitled to receive a copy of this authorization.
- A copy of this authorization shall be as valid as the original.
- The authorization shall be valid throughout the life-cycle of the claim, including adjudication, auditing, and quality control activities.

I have reviewed and understand the content and purpose of this acknowledgement and authorization. By signing I am confirming that the authorization noted above accurately reflects my wishes.

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