

Please attach original bills

**SECTION A. ENROLLEE AND PATIENT INFORMATION**

PATIENT'S CGI IDENTIFICATION NUMBER:	PATIENT'S DATE OF BIRTH:	CGI POLICY ID/ POLICYOWNER/ PLAN SPONSOR:
PATIENT'S NAME (Last, First, Middle):	PATIENT'S RELATION TO ENROLLEE: [ ] Self [ ] Spouse [ ] Child [ ] Other	ENROLLEE'S NAME (Last, First, Middle):
PATIENT'S MAILING ADDRESS (P O Box):	PATIENT'S STATUS: [ ] Single [ ] Married [ ] Other [ ] Employed [ ] Student [ ] Other	ENROLLEE'S MAILING ADDRESS (P O Box):
PATIENT'S STREET ADDRESS:	PATIENT'S CONDITION RELATED TO: [ ] Employment, date: _____ [ ] Auto accident, date: _____ [ ] Other emergency, date: _____	ENROLLEE'S STREET ADDRESS:
PATIENT'S PHONE & FAX NUMBERS:	[ ] Pregnancy, LMP: _____ [ ] Substance abuse, date: _____	ENROLLEE'S PHONE & FAX NUMBERS:
PATIENT'S OTHER HEALTH INSURANCE (if any):	[ ] Other, date: _____	ENROLLEE'S OTHER HEALTH INSURANCE (if any):

<p align="center"><b>PATIENT'S AUTHORITY</b></p> <p>I authorise Cayman First Insurance Company Limited to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.</p> <p>Signature _____ Date _____</p>	<p align="center"><b>PAYMENT ASSIGNMENT</b></p> <p>I authorise Cayman First Insurance Company Limited to pay the proceeds of this claim to the undersigned Medical Services Provider.</p> <p>Signature _____ Date _____</p>
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**SECTION B. MEDICAL PROVIDER INFORMATION**

DATE OF FIRST SYMPTOM OR LMP:	IF PATIENT HAD SUFFERED SAME OR SIMILAR ILLNESS BEFORE, GIVE DATE(S):	IF PATIENT WAS UNABLE TO WORK DUE TO THIS ILLNESS, GIVE DATE(S):
NAME AND ADDRESS OF REFERRING OR PREVIOUS PHYSICIAN, OR OTHER SOURCE:		IF PATIENT WAS HOSPITALISED FOR THIS ILLNESS, GIVE DATE(S):
DATE YOU FIRST TREATED PATIENT FOR THIS ILLNESS:	WAS OUTPATIENT DIAGNOSTIC SERVICES ORDERED, OR MEDICATION PRESCRIBED? [ ] Yes [ ] No	NATURE OF ACCIDENT, IF APPLICABLE:

DIAGNOSIS, ILLNESS OR INJURY*		TREATMENT SERVICES*				
CODE	DESCRIPTION	DATE(S)		CODE	DESCRIPTION	CHARGE CI \$
		From	To			

\* If required, additional information may be detailed on the reverse side of this form.

PATIENT ACCOUNT NO:	ACCEPT ASSIGNMENT? [ ] Yes [ ] No	TOTAL CHARGE: CI \$	PATIENT RESPONSIBILITY: C	BALANCE OUTSTANDING: CI \$
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I certify that the information furnished above is true and correct to the best of my knowledge.

PROVIDER NAME:	PROVIDER TELEPHONE NUMBER:	PROVIDER REGISTRATION NUMBER:
PROVIDER ADDRESS:	PROVIDER'S SIGNATURE:	DATE:

