HOSPITALIZATION CLAIM FORM

Claimant's Statement

The undersigned makes claim for benefits and authorizes any hospital, surgeon, physician or other person to release and furnish Family Guardian Insurance Company Ltd., or its representative any and all information concerning any illness or injury, including medical history, consultations or treatments and copies of all hospital or medical records that same may be included as a part of the proofs of claim submitted to the Company. It is understood that the furnishing of this form shall not constitute nor be considered an admission by the Company that there was any insurance in force, nor constitute a waiver of any of the Company's rights or defenses. A photo-static copy of this authorization shall be considered as effective and valid as the original.

Date: MM DD YY **Signature:**

Assignment of Hospital Benefit

I hereby authorize payment directly to the hospital named below, the hospital benefit otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this assignment.

Date: MM DD YY **Signature:**

HOSPITAL STATEMENT

(Please Print)

Patient's Name:		**HOSPITAL CHARGES**		
Date of Birth:		*(Complete this section or attach itemized bill)*		
		Room & Board		
Address:		Days at	Total:	$
Diagnosis *(from records)*:		Days at	Total:	$
Date of First Symptom:		Operation Room:	Total:	$
Admission Date:	Hour:	Lab:	Total:	$
Discharge Date:	Hour:	X-Ray:	Total:	$
Hospital:		Anesthesia:	Total:	$
Signature:			**TOTAL:**	$
Title:			**Less amount paid by patient:**	
Date:			**BALANCE DUE:**	$

Assignment of Physician/Surgical Benefit

I hereby authorize payment directly to the physician's fee or surgical operation benefit otherwise payable to me, but not to exceed the charges for such physician's services or surgeon's operation. I understand I am financially responsible to the physician or surgeon for the fees or charges not covered by this assignment.

Date: MM DD YY **Signature:**

Please Turn Over

PHYSICIAN'S OR SURGEON'S STATEMENT

(Please Print or Type)

To be completed in all cases when surgical benefits are claimed and in other cases when hospital statement does not give diagnosis and date of first symptoms

Patient's Name: Date of Birth:

Physician's/Surgeon's Name: Is illness related to pregnancy? ☐ Yes ☐ No

Date of First Symptom: History of Similar Attacks? ☐ Yes ☐ No

If yes, please explain

Diagnosis:

Operation Performed: Date:

Circumstances Surrounding Injury:

Is Illness Due to Accident? ☐ Yes ☐ No

No. Physician's Visits: Fee Charged: $ Maternity Fee(s) *(Delivery fees excluding Prenatal & Postnatal care):* $

Signature of Surgeon/Physician: Date:

Full Address:

TO BE COMPLETED BY FAMILY GUARDIAN

Policy No.	Policy Date	Plan Code	Age	Premium	Daily Benefit	Daily Surgical	District	Agency	D.I.P

Benefit				**Total Paid**		
Daily:	Days at		Per Day	$		
Surgical:	% of			$		
Anesthetist:	% of			$		
Maternity:	Days at		Per Day	$	Examined by:	
Cancer:	Days at		Per Day	$		
Surgical:	% of			$	Approved by:	
Anesthetist:	% of			$		
Daily Intensive Care:	Days at		Per Day	$		
Attending Physician's Fee:	Days at		Per Day	$		
Accidental Benefit:	Days at		Per Day	$		
Eligible Outpatient Services up to:			Per Day	$		
Miscellaneous Hospital Expense Benefit up to:			Per Day	$		
Actual Charges:				$		
				Total of Claim: $		

Waiver of Premium Benefit. Insured confined from: To:

Premiums waived from: To:

Payee Hospital:	Amount	$	Cheque No.:	
	Amount	$	Cheque No.:	
Payee Doctor:	Amount	$	Cheque No.:	
	Amount	$	Cheque No.:	
Payee Anesthetist:	Amount	$	Cheque No.:	
Payee Insured:	Amount	$	Cheque No.:	
	Total Paid	$		

Date Paid: **Records Posted By:**