FAMILY GUARDIAN
INSURANCE COMPANY LIMITED

SICKNESS & ACCIDENT

This Company is not liable for claim unless the illness or accident is such that confines patient to the home or prevents him/her from performing his/her duties. Otherwise claim will be rejected.

TO BE SIGNED BY THE INSURED

I hereby authorize the physician or surgeon treating me for my illness or injury mentioned below to release the information and any other records that may be requested by Family Guardian Insurance Company, Ltd., or it representatives. I hereby agree to reimburse Family Guardian Insurance Company, Ltd. to the extent of any overpayment, which is in excess of the amounts payable under this plan.

Signature of Insured: **Date:**

TO BE COMPLETED BY ATTENDING PHYSICIAN OR SURGEON *(Please Print)*

Name of Patient: **Age:** **Date of Birth:** MM DD YY

Telephone Number(s): **Sex:** ☐ Male ☐ Female

Address:

Date of first symptom: MM DD YY **Patient's temperature *(if pertinent)*:**

Nature of Illness/Injury:

Did patient have surgery: ☐ Yes ☐ No **Type of surgery performed:**

Is patient pregnant: ☐ Yes ☐ No **Is illness related to pregnancy:** ☐ Yes ☐ No

Date patient first attended you for illness: MM DD YY

Date patient last attended you for illness: MM DD YY **Is patient unable to work:** ☐ Yes ☐ No

If disabled, for what period *(From/To)*:

I hereby declare that the above answers are true and complete to the best of my knowledge.

Attending Physician/Surgeon's Signature **Date**

Address: **Telephone Number(s):**

TO BE COMPLETED BY AGENT FOR COMPANY USE

☐ W.P. ☐ H.S.O.

First day lost from work: **Date returned to work:**

Total work days lost: **Benefit Schedule:** **Amount Paid:** $

Approved by: **Date:**

District #	Agency #	Policy #	Issue Date			Age	Premium	Death Bene.	D.L.P.			L.R. Folio
			M	D	Y				M	D	Y	
Life Ins.												
Life Ins.												

No. Claims for Illness: **No. Claims for Year:** **Agent's Signature:**

RECEIVED FROM FAMILY GUARDIAN INSURANCE COMPANY LIMITED

Date: **Amount:** $

Being the full benefits due me under the above listed Sickness & Accident Insurance for the period of days ending:

X Witness

X Signature of Insured/Beneficiary

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