REIMBURSTMENT CLAIM FORM

PAN AMERICAN
Private Client
*A member of the Pan-American Life Insurance Group**

Dear Insured:

Our duty is to provide you with the highest level of service and quality. For this reason, we have created the Reimbursement Claim Form, which is designed to expedite the review claim process.

Although Pan-American Life Insurance Company offers the possibility to directly liquidate your medical expenses with the medical provider and then receive a reimbursement, according to the provisions and conditions stated in your policy, we recommend to use Pan-American Medical Services as your first option to program your admissions, monitor your medical services at the hospital, contact your doctors, establish direct payments and, in this way, control expense.

Please review the following points carefully before submitting the requested information:

- Fill out all the requested information. Please write in print.
- If preferred to receive a refund through a bank transfer, please fill out the bank account information carefully. Please include a voided check to verify the information, in case it is necessary.
- If you already have additional coverage, claims must be initially processed by the current insurance company and send us the benefits summary and copies of receipts.
- Depending on whether it is the first medical visit or a routinary visit, it is required to submit separate forms for each insured and for each incident with the updated information.
- Please do not forget to sign your claim. Your doctor's seal, professional license number and signature are also required for the application to be accepted.
- In the case where more than one doctor is requesting payment for the same diagnostic or event, each of them needs to fill out a form for a first visit or evolutionary visit.
- If you have suffered an accident, please submit the following information: medical emergency and radiology report, in case of a nasal trauma.
- If you have suffered a car accident, please submit the police report; if no police case has been filed, please submit the all medical information available.
  (Information from the car insurance company would also be required. If the insured has no car insurance, a letter must be presented.)
- Please attach the insured's address, original invoices and receipt of payments to the following address within 180 days from the date of service:

Pan-American Private Client
121 Alhambra Plaza, Suite 1501
Coral Gables, FL 33134

CLAIM REIMBURSEMENT FORM

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I- MAIN INSURED'S INFORMATION:

Name of Main Insured (Last name, first name and middle initial)

Policy number #

Mobile

Email

II- PATIENT'S INFORMATION:

Name of Insured Patient (Last name, first name and middle initial)

Date of birth
Month/Day/Year

Sex

○ **M**
○ **F**

Relationship to Main Insured (if applicable) ○ Spouse ○ Child ○ Other

III- DETAILS OF DIAGNOSIS, ILLNESS, OR ACCIDENT:

Is this claim resulting from an accident? ○ **Yes** ○ **No**

If Yes, was the injury caused by the act or omission of a person other than the patient? ○ **Yes** ○ **No**

Diagnosis, nature of illness, or type of accident:

Date of first symptom or date of accident

Date of first consultation for this diagnosis, illness, or accident

Have similar symptoms occurred previously? ○ **Yes** ○ **No** If Yes, when?

IV- IN CASE OF HOSPITALIZATION:

Name of the Hospital

Period of hospitalization From To

V- OTHER HEALTH INSURANCE:

In connection with this diagnosis, illness, or accident, have you made a claim, or are you making a claim, against any other health insurance policy? ○ **Yes** ○ **No**

If Yes, please include: Name of Company Policy number

*Underwritten by Pan-American Life Insurance Company (PALIC) of New Orleans, LA U.S.A. and administered by Pan-American Private Client in Coral Gables, FL U.S.A.

121 Alhambra Plaza, Suite 1501 | Coral Gables, Florida 33134 | Telephone: +1-305-961-1606 | Fax: +1-855-220-7327 | Email: service@paligpc.com | Website: www.paligprivateclient.com

VI- PREFERRED METHOD OF REIMBURSEMENT:

○ Cheque ○ Wire transfer to a bank in the USA ○ Wire transfer to a bank outside the USA

if the method for reimbursement is thru Wire Transfer, please complete sections VII and VIII.

VII- BANK ACCOUNT INFORMATION (FOR TRANSFERS TO USA BANKS):

Name of the beneficiary bank:

Branch number and address:

ABA number for ACH transfers (for US banks only): Account number:

SWIFT code (for banks outside the USA): Account number:

Sub account or final account (If any): Account holder:

VIII- INTERMEDIARY BANK (FOR TRANSFERS TO BANKS OUTSIDE THE USA):

Name of bank:

Branch number and address:

Account number: SWIFT code:

IX- TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of Attending Physician (Last name, first name and middle initial)

Attending Physician's registration or license number

Attending Physician's address

Address

City | State | Zip Code | Country

Telephone | Email

Date of consultation

Attending physician's signature and stamp

I certify that the information provided in sections VII and VIII is complete and correct to the best of my knowledge.

X- WHAT IS THE PAST OR CURRENT TREATMENT?

Date of service	Service provider	Description of services rendered	Currency	Charges

Total charges	
Amount paid by the insured	
Amount paid by other insurance	
Balance due to hospital, clinic, doctor, etc.	

XI- AUTHORIZATION AND SIGNATURES:

I certify that the statements on this form are complete and correct to the best of my knowledge. Upon presentation of a photocopy of this signed authorization, I hereby authorize any medical professional, hospital, medical care institution, pharmacy, governmental healthcare agency, insurance company, employer benefit plan administrator and/or quality control company to release any and all past or present medical information concerning myself or my dependents, and any and all statements of amounts due. I understand that the information authorized herein will be used by PALIC to evaluate this claim for insurance benefits. Any confidential medical information obtained in assessing this claim can be released to any person or organization PALIC deems necessary.

Main Insured's Signature	Patient's signature
Date	Date