MEDICAL CLAIM FORM

Premier Assurance Group SPC Ltd. (in Provisional Liquidation) (the "Company") and its segregated portfolio: Global Assurance Segregated Portfolio ("GASP") which insures policies written through Premier Health or PA Global Trust.

POLICYHOLDER INFORMATION

1.	Name of Primary Policyholder (Last, First, MI):	
2.	Policy Number:	
3.	Physical Mailing Address:	
4.	Telephone:	
5.	Email Address:	

PATIENT INFORMARION

6.	Patient Name (Last, First, MI):						
7.	Date of Birth (MM/DD/YYYY):						
8.	Was this claim pre-certified?	☐	YES	☐	NO		
9.	Is the claim covered by another insurance?	☐	YES	☐	NO		
	If Yes, please provide the name of the insurance company:						
	Note: If your claim was submitted to a local insurance provider, you must submit a copy of the Explanation of Benefits (also referred to as finiquito) and medical bill before the JPLs can process the claim						
10.	Type of Service:	☐	Routine Wellness	☐	Medical	☐	Maternity
		☐	Routine Vision	☐	Accident		
		☐	Other:				
11.	Length of days:						
12.	Date of onset of the illness (MM/DD/YYYY):						
13.	Admitted as:	☐	Inpatient				
		☐	Outpatient				
		☐	Emergency				
14.	Country of Treatment:						
15.	List of medical services: *Note: Each one of the items listed below is required to have a copy of the corresponding medical invoice in PDF format.*						

	Date of Service (MM/DD/YYYY)	Place of Service	Diagnosis and Procedure	Amount and Currency
a.				
b.				
c.				
d.				
			Total:	

PAYMENT INFORMATION FOR REIMBURSEMENT

16.	Please provide the following bank details for reimbursement via wire transfer or ACH payment.	
a.	Account Number:	
b.	Name of the Account Holder:	
c.	Routing Number:	
d.	Name of Bank:	
e.	Intermediary Bank (if applicable):	

The JPLs reserve rights to request further information in due course