MATERNITY QUESTIONNAIRE

Claim Form, original itemized bills and all related correspondence must be mailed to:

Sagicor Allnation Insurance Company
c/o Sagicor International Management Svcs.
4010 W. Boy Scout Blvd., Suite 800
Tampa, Florida 33607-5735 USA

Toll Free: (800) 342-0719
Telephone: (813) 286-2222
Fax: (813) 287-7420

Insurance products provided by
Sagicor Allnation Insurance Company
http://www.allnation.com

MATERNITY QUESTIONNAIRE MUST BE COMPLETED BY THE ATTENDING OBSTETRICIAN AT THE FIRST VISIT

A. PATIENT INFORMATION

Name (Last, First, MI):	Alias:
Date of Birth (MM/DD/YY):	
Policy ID Number:	Policyholder Name:
Date of Last Menstrual Period (MM/DD/YY):	
History of Fertility/Infertility Treatments (*Include all medications, surgical procedures, etc. for the past 3 years*):	
Is the patient in an In Vitro Fertilization Program? ☐ Yes ☐ No	
Expected Date of Delivery (MM/DD/YY):	
Anticipated Type of Delivery (check one): ☐ Vaginal ☐ Cesarean Section	
Anticipated Amniocentesis or other testing to be performed *(If tests are performed, results should be sent to Sagicor Allnation Insurance Company):*	

B. PHYSICIAN INFORMATION

Name (Print)	
Signature:	Date Signed:
Address:	
Telephone Number:	

C. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

PLEASE ATTACH THE INITIAL OBSTETRICAL EVALUATION/EXAMINATION AND SUBMIT TO THE ADDRESS ABOVE. MATERNITY RELATED SERVICES CANNOT BE PROCESSED WITHOUT THE SUBMISSION OF THIS FORM.

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