Dental Claim Form

Section A

Policy/Member Information

Name of Patient:

Policyholder name:

Policy Number:

Member Number:

Contact Details (if different from policy)

Address:

Country:

Telephone (H)

Telephone (O)

Facsimile:

☐ Send settlement to this address

To be answered if this claim pertains to an Accident

Date, time, and exact place of accident:

Briefly describe how this accident occurred:

Was a third party involved? If yes, please describe his/her part in this accident, and state whether reimbursement or other compensation will be provided.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorize any dentist, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization who may have records pertaining to such accident to release such records or information.

I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law.

I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member (parent if minor) Date

Important:

- Have you completed Section A?
- Have you signed the Declaration and Authorization for Release of Information?
- Have you enclosed all original bills, statements, receipts, and other documents?
- Has the dentist completed Section B?

Please send completed form and all original bills, statements, receipts, and other documents to:

GlobalHealth Asia Limited
Suite 1401-3, Chinachem Hollywood Centre
1–13 Hollywood Road, Hong Kong
Telephone (852) 2526-0505 Facsimile (852) 2526-0769

Section B

To be completed by Dentist

1. Please complete the tooth chart for dental services.

2. In case of accident or injury

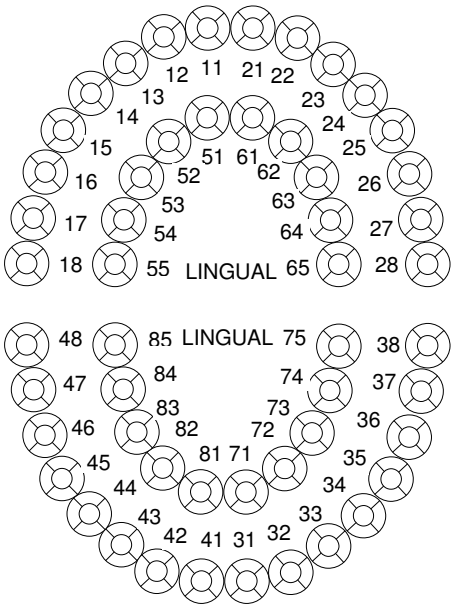
   Were teeth natural and free from decay, defects, or prior restoration/appliances at the time of the accident? If unknown, please state your opinion.

   ☐ No ☐ Yes (please explain)

   Was accident in any way connected with the patient's employment or job duties?

   ☐ No ☐ Yes (please explain)

Tooth Chart



Directions:

1. Mark fillings by shading in the appropriate space

2. Mark extractions with "X"

3. Mark crowns with a "C"

4. Mark bridges with a "B"

Itemization of Services

Tooth	Surface	Description of Services	Date	Fee

Name And Address of Dentist Signature of Dentist Date