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redefining / insurance

Dental claim form

Date received:

This claim is not an admission of liability.

Dear Member, we thank you for completing all sections of this claim form and for signing and dating it. All fields on the front page and the patient's signature at the Patient's Declaration on the second page are compulsory. We thank you in advance for your cooperation which will facilitate prompt processing of your claim.

A. PATIENT DETAILS

Policy/membership no.:		Policy/company name:
Patient date of birth: dd / mm / yyyy	Gender:	Patient name:
NRIC No./FIN/Passport no.:		Plan:
Email address:		Patient phone:

B. CLAIM DETAILS

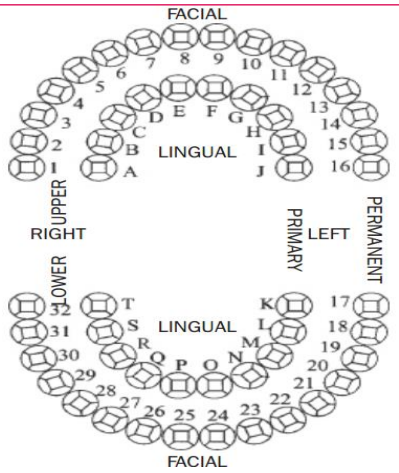
Duration of illness:

Date of Consultation: dd / mm / yyyy

Chief complaint and main symptoms:

Diagnosis:

Other Conditions:



Please Tick (❑) where appropriate:

- ❑ Routine dentistry
- ❑ Orthodontics/ esthetics
- ❑ Check-up
- ❑ Work related accident
- ❑ Congenital/development
- ❑ Road traffic accident related
- ❑ Sports Related

Specify the recommended investigations, and/or procedures using the tooth number as shown on the teeth map above

Service code	Service description	Tooth no. / Letter	Service cost

C. TREATMENT ADVISED / FUTURE TREATMENT PLANNED

Please give details of any drugs prescribed and / or any further planned treatment

D. OTHER INSURER'S DETAILS

Is the treatment accident related? Yes ❑ No ❑
(If you have answered 'yes', please give details of the accident.)

Is it covered under another insurance policy? Yes ❑ No ❑

If you have answered 'yes' to either of these questions, please give the name of the insurance company involved.
(Kindly submit a copy of the other insurance company's claim settlement letter/ payment voucher)

E. PAYMENT DETAILS

Amount claimed:
Please ensure that the amount claimed here is supported by original invoices and prescription.

Cheque beneficiary name : (IN CAPITAL LETTERS)

Telegraphic bank transfer: (Bank details will be required if previously not declared in application form)

Bank account no: Bank SWIFT code:

Name of bank: Bank address:

Payment will be made in the currency defined in your plan unless we agree otherwise in writing.
In which currency was the treatment originally billed?

Member's and patient's details

Patient's name and address:

Telephone no:	Email address:

Mobile no:

Address to which payment should be sent if different from above:

PATIENT'S DECLARATION

I confirm that I am the patient or patient's parent or guardian and I declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorise the medical practitioner involved in my or the patient's care to discuss and disclose treatment details, discharge arrangements and relevant medical history with and to AXA Insurance Singapore Private Limited. I agree that a copy of this consent shall have the validity of the original.

In connection with my and/or my dependant's claims, I give consent for AXA Insurance Singapore Private Limited and AXA Life Insurance Singapore Private Limited (collectively "AXA") and their respective representatives or agents to collect, use, store, transfer and/ or disclose the information (including that provided by sources other than myself) concerning me and/or my dependant's, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore and the Employer when claiming under a Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me and/or my dependant's (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my and/or my dependant's claims or the Employer's Group Policy(ies) with AXA (as the case may be), and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purposes").

DD MM YYYY

Patient's Signature (Parent's or Guardian's signature if Patient is a Minor) Date

If you have any questions regarding this form or any other aspects of the cover, please contact our Health Service Team on 1800 880-8181 (+65 6880 8181 if dialing from outside of Singapore) quoting your policy/membership numbers. Claims must be submitted along with supporting documents within 90 days from date of service. Send this claim form together with supporting material to Health Service Team, AXA Insurance Singapore Pte Ltd, 8 Shenton Way #27-01, AXA Tower, Singapore 068811.