

GlobalHealth Plan Dental Claim Form

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PLEASE COMPLETE ALL SECTIONS TO FACILITATE THE PROCESSING OF YOUR APPLICATION

This form must be completed truthfully and accurately.

The list of documents required is not exhaustive and we reserve our right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned together with all supporting documents as soon as possible to the following address:

Chartis Singapore Insurance Pte. Ltd.
CHARTIS Building, 78 Shenton Way, #07-16, Singapore 079120

The acceptance of this Form is NOT an admission of liability on the part of Chartis Singapore Insurance Pte. Ltd. ("the Company"). Any documentary proof or report required by the Company shall be furnished at the expense of the Policyholder or Claimant.

Section A - General Information

Policy/Member Information	Contact Details (if different from policy)
Name of Patient:	Send settlement to this address: <input type="checkbox"/> Yes
Identity Card / Passport No.:	Address:
Name of Policyholder:	Country:
Policy Number:	Telephone: (H) (O)
Member Number:	Facsimile: E-mail 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 are 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.

Authorisation for Release of Information
I authorise 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 therefore. If this claim relates to an accident, past or present, I also authorise 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.

Any information collected or held by Us whether contained in the Application / Proposal or Claim Form or otherwise obtained in any other manner, may be used and disclosed to Our associated individuals / companies or any independent third parties (within or outside Singapore) for any matters related to your claim and to communicate with You for any purpose.

Signature of Member
(to be signed by parent if member is a minor)

Date

Important Note (to Claimant):

- Have you completed Section A?
- Have you signed the Declaration and Authorisation for Release of Information?
- Have you enclosed all original bills, statements, receipts and all relevant documents?
- If required, has your Physician completed and signed Section B?
- Please contact GlobalHealth at tel: 6557 0896 or fax 6557 0796 if you have questions on how to submit your claim.

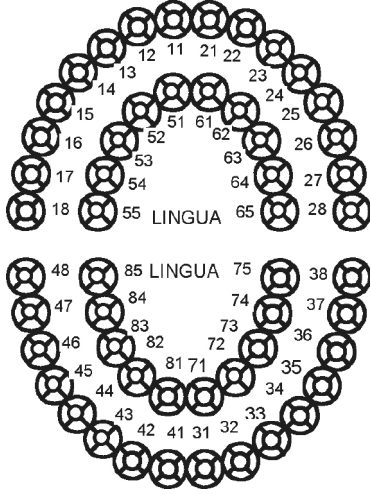




Section B (to be completed by Dentist)

1. Please complete the tooth chart for dental services.

2. In case of accident or injury

a) Were teeth natural and free from decay, defects, or prior restoration/appliances at the time of the accident? If unknown, please state your option. No Yes

b) Was accident in any way connected with the patient's employment or job duties? No Yes

Tooth Chart	Itemization of Services				
	Tooth	Surface	Description of Services	Date	Fee
 <p>Directions:</p> <p>1. Mark fillings by shading in the appropriate space </p> <p>2. Mark extractions with 'X' </p> <p>3. Mark crowns with a 'C' </p> <p>4. Mark bridges with a 'B' </p>					

Name and Address of Dentist

Signature of Dentist

Date