

AIG GlobalHealth Plan

Dental Claim Form

Section A

Policy/Member Information

Name of Patient: _____

Identity Card / Passport No.: _____

Name of Policyholder: _____

Policy Number: _____

Member Number: _____

Contact Details (if different from policy)

Send settlement to this address: Yes

Address: _____

Country: _____

Telephone: _____ (H) _____ (O)

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 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 : _____
(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 Authorization for Release of Information?
- Have you enclosed all original bills, statements, receipts and all relevant documents?
- Has the dentist completed Section B?

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

GlobalHealth Asia Pte Ltd

133 New Bridge Road #17-03 Chinatown Point, Singapore 059413
Telephone 6557-0896, Facsimile 6557-0796

