DENTAL CLAIM FORM

PACIFIC CROSS

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient: _____ Sex: _____

Date of Birth (day/month/year): _____ Member No.: _____ Policy No.: _____

If group insurance, name of the Policyholder: _____

SECTION B – STATEMENT BY THE PATIENT

1. If any the above treatments or services were necessitated as a result of an accident, please state the occurrence of the incident.

_____

_____

2. When and where did the accident occur?

_____

_____

_____

3. Was the accident of nature requiring report to the police?

If so, was the accident reported? ❑ Yes ❑ No

When and where was it reported?

_____

SECTION C – AUTHORIZATION & DECLARATION

I hereby authorize any hospital or dentist or other person who has attended me to furnish to insurance company (and its representative) and permit the said insurance company (and its representative) to review any and all information requested with respect to any illness, or accident, dental history, consultation, prescription or treatment and copies of all hospital or dental records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

In case I designate an Account Holder's Name to receive the payment of insured benefits that is not the account of the Insured under the Policy, I undertake to: be solely responsible and bear legal risks; undertake not to dispute, claim any content related to the payment by the Company under my appointment under this Claim Form.

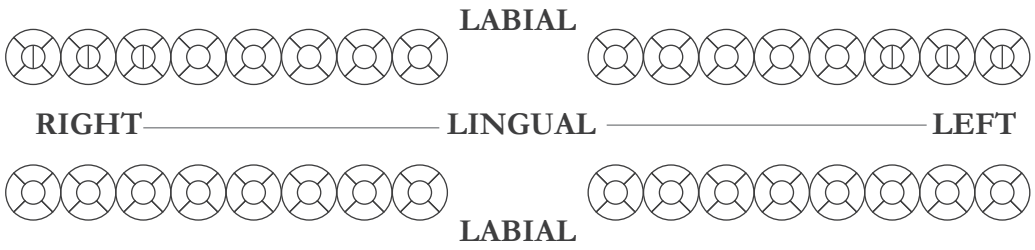
_____ _____

Date (day/month/year) Signature of Patient (or Parent if a minor)

SECTION D- ATTENDING DENTIST'S REPORT

Treatment Date	Treatment Provided	No. of Tooth	Charges
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please mark teeth treated or area of oral treatment on the following chart:



Name of Dentist: _____

Address: _____

_____

Telephone No.: _____

E-mail: _____

_____

Signature of Dentist

Date (day/month/year): _____

** Please attach all invoices and other relevant documents*

SECTION E - PAYMENT DETAILS

a. Payment to Policyholder / Insured Person

Preferred payment method

- ❑ Cash
- ❑ Bank Transfer (Please fill in the VND bank details below)

Account Holder's Name: _____

Account No.: _____

Bank Name: _____

Bank Address: _____

b. Payment to Medical Provider

Has direct billing been agreed with **Pacific Cross Vietnam** ? ❑ Yes ❑ No