GROUP DENTAL CLAIM FORM

Dear insured employee / spouse or child ("life insured"),

We refer to your claim for dental reimbursement.

In order for us to process your claim, we require the following:

(1) Group Dental Claim Form (to be completed by life insured)
(2) Original medical invoices / receipts / bills

Please complete **all** questions in the form for prompt settlement of the claim.

Once we have received **all** the above required documents, we will process your claim accordingly.

All the required documents must be forwarded to our company within **30 days** from the date of consultation.

TOKIO MARINE
INSURANCE GROUP

GROUP DENTAL CLAIM FORM

IMPORTANT NOTES:
(1) The issue of this claim form is not an admission of liability
(2) Tokio Marine Life Insurance Singapore Ltd. ("TMLS") reserves the right to request for additional medical reports when it deems necessary
(3) This form is to be completed by the life insured

Name of employer: _____ Group Policy No.: _____

Name of employee: _____ Date of employment: _____

NRIC / Passport No.: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Marital status: _____

Designation: _____ Plan: _____

DETAILS OF PATIENT (IF DIFFERENT FROM EMPLOYEE)

Name of patient: _____

Relationship to employee: _____

NRIC / Passport No.: _____ Date of birth: _____

Occupation: _____ Gender: ☐ Male ☐ Female

DETAILS OF CLAIM

Type of dental treatment: _____

_____

_____

Declaration

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

Personal Data Notice

I agree and consent that TMLS may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or TMLS's Data Protection Policy available at www.tokiomarine.com, which I have read, understood and agreed to the same.

_____ _____
Signature of Life Insured Date (dd/mm/yyyy)

Contact No(s) : _____ Email : _____

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