GROUP DENTAL CLAIM FORM

CLAIM SUBMISSION PROCEDURES

Please read carefully before

1. The Great Eastern Life Assurance Company Limited (The Company) does **not admit liability** by the mere issue of this Form.
2. Please pay the dentist after your treatment and ask the dentist to complete Part II of the Claim Form.
3. Please submit the Claim Form and all claim documents (see below) within **30 days** from incurring the expenses.
4. Please submit only **original final itemised bills** (not summarized bills) and receipts. Photocopies of bills/receipts are **NOT** acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.

DENTAL CODES

Consultation & Preventive	Code
Oral Examination	A1100
Prophylaxis	A1200
Fluoride Treatment	A1300
Endodontics	
Pulp Capping	B1100
Root Canal Therapy (inclusive of temporary filling)	
Single Canal	B1200
Two Canals	B1300
Three Canals	B1400
Crown (excluding cost of precious alloy)	
Crown - Provisional Only	C1100
Crown - Metal Full	C1200
Crown - Porcelain Full	C1300
Crown - Porcelain bonded to metal crown	C1400
Crown - Recementation	C1500
Dentures	
Acrylic Complete Upper	D1000
Acrylic Complete Lower	D1100
Acrylic Immediate Upper	D1200
Acrylic Immediate Lower	D1300
Acrylic Partial Denture (Including Base)	
-Per Tooth	D1500
Metal Partial Denture (Including Base)	
-Per Tooth	D1700
Diagnostic Plaster Cast	Q1000
Extractions	
Anterior Tooth	E1000
Posterior Tooth	E1100
Preprosthetic Alveoloplasty	
Alveoloplasty	F1000
Inlay/Onlay - Metal Composite	
Porcelain (Basic fee excluding precious alloy)	
One surface	I1600
Two surfaces	I1700
Three surfaces	I1800

Medication	Code
Analgesics - oral only	M1000
Antibiotics - oral only	
Administration of Local Anaesthesia	
Sedative dressing	M1100
Periodontics	
Root Planning Per Tooth	P1100
Root Planning Per Quadrant	P1200
Surgical Extractions	
Surgical removal erupted tooth	S1000
Surgical removal tooth roots	S1100
Surgical removal impacted tooth (Simple)	S1200
-soft tissue	
Surgical removal impacted tooth (Difficult)	S1300
-completely bony	
Surgical removal impacted tooth (Complicated)	S1400
-completely bony with unusual surgical approach	
Radiographs	
Periapical Film	X1000
Bite-Wing	X1100
Occlusal File	X1200
Orthopantograph	X1300
Restorative (Filling only)	
Amalgam Restorations:-	
Amalgam - one surface	R1100
Amalgam - two surfaces	R1200
Amalgam - three & more surfaces	R1300
Composite Restoration:-	
Composite Resin - one surface	R2200
Composite Resin - two surfaces	R2300
Composite Resin - three & more surfaces	R2400
Retention Pins	R2500

All claimants are to note that the benefits listed here are used as a reference guide for the dentist to complete the Claim Form. The precise terms and benefits are governed by the Master Policy issued to the Policyholder.

Important Note: Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.

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Great Eastern
A member of the OCBC Group

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PART I - STATEMENT BY POLICYHOLDER (EMPLOYER)

Name of Employer (Policyholder):

Employee Plan Type:

*Please state to whom benefit payment should be made to:

Policy No:

___ Employer ___ Employee

Name of Employee (Insured Member):

NRIC/Passport No:

Sex:

Male Female

Name of Patient:

NRIC/Passport No:

Relationship to Insured Member:

Spouse Child

Sex:

Male Female

Email Address:

For Payments by GIRO: Please complete the Employee's Bank Account below.

Name of Bank	Branch of Bank	Bank Account Number	Account Holder's Name

Important Notes:

a. Please fill in only the Employee's Bank Account as the Company will not allow creditng to any othe bank account.

b. The Company will not be held liable for any damages, costs, losses or expenses as a result of the claims proceed being credited into the Bank Account shown above.

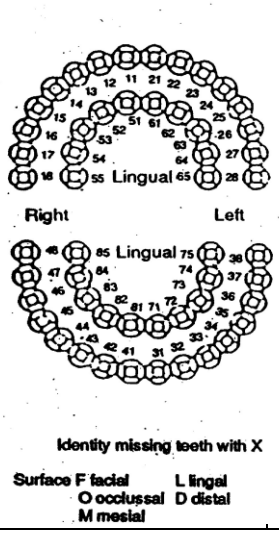
c. The Company will continue to credit all future/further claim benefits to the above Bank Account, unless otherwise notified by the Policyholder/Employee.

d. Please note that GIRO payment applies to bank accounts in Singapore only.

Authorised Signatory & Date:	Name of Authorised Signatory :	Company's Stamp :

PART II - REPORT BY DENTIST

TO BE COMPLETED BY ATTENDING DENTIST



Examination & Treatment							
List Tooth Order Using Chart System				Date Service Performed			Fee ($)
Tooth no or Ltr	Surface	ProcedureCode	Please describe procedure (if not listed overleaf)	Day	Month	Year	
				Total fee charged			

Dentist Declaration

I hereby certify that the service listed above have been performed on the abovementioned patient on the dates indicated.

Signature of Doctor/Surgeon

Name, Address and Qualification of Doctor/Surgeon

Date :

(to affix Doctor's Stamp)

PART III - DECLARATION BY PATIENT OR INSURED MEMBER (IF PATIENT IS A MINOR)

a. I agree to the treatment and the fee charged.

b. I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

c. I hereby authorise Great Eastern Life to disclose and/or to obtain from any Insurance Company any & all information with respect to this or any related claim.

d. I hereby authorise any hospital, medical practitioner, clinic or any other person who has medically attended to or examined me or my eligible dependent to disclose to Great Eastern Life all medical records or information with respect to any illness or injury, medical history, consultations, prescription or treatment and copies of all hospital records.

e A photostat copy of this authorisation shall be considered as effective and valid as the original.
By providing the information set out above, I agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or settle my claims. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at https://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood.

Date : _____ Signature of Patient/Insured Member : _____

* *please tick in the appropriate boxes.*

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
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Tel 6248 2000 Fax 6532 3478 Website: greateasternlife.com