DENTAL CLAIM FORM

Please complete the following information and attach this form with your claims. One form is required for each Insured Person (Patient).

Please send all claims and inquiries to: **Pacific Cross Insurance Company Limited**
c/o International Administrators Limited
11/F, O.T.B. Building, 160 Gloucester Road, Wanchai, Hong Kong, SAR
Tel: (852) 2573 2535 Fax: (852) 2573 2917
E-mail: customerservice@pacificcross.com Website: http://www.pacificcross.com

SECTION A – PARTICULARS OF THE INSURED PERSON / PATIENT

Name of Policyholder		Policy No.
Name of Insured Person (Patient)		Member No.
Date of Birth (MM/DD/YY)	Sex	No. of Bill / Receipt / Statement

SECTION B – STATEMENT BY THE INSURED PERSON / PATIENT

(complete if as a result of accident and by parent if patient is a minor)

1. When and where did the accident occur?

2. Please state the occurrence of the incident:

3. Have you ever filed or are you going to file this claim under any other insurer? Yes ☐ No ☐

If "Yes", please provide claims settlement report.

SECTION C – AUTHORIZATION & DECLARATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility who has attended me to furnish to **PACIFIC CROSS INSURANCE COMPANY LIMITED** (or its representative) and permit the said insurance company (or its representative) to review any and all information requested with respect to any illness or accident, medical history, consultation, prescription or treatment and copies of all hospital or medical 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.

Date

Signature of Patient (or Parent if a minor)

Please Turn Over

SECTION D – ATTENDING DENTIST'S REPORT

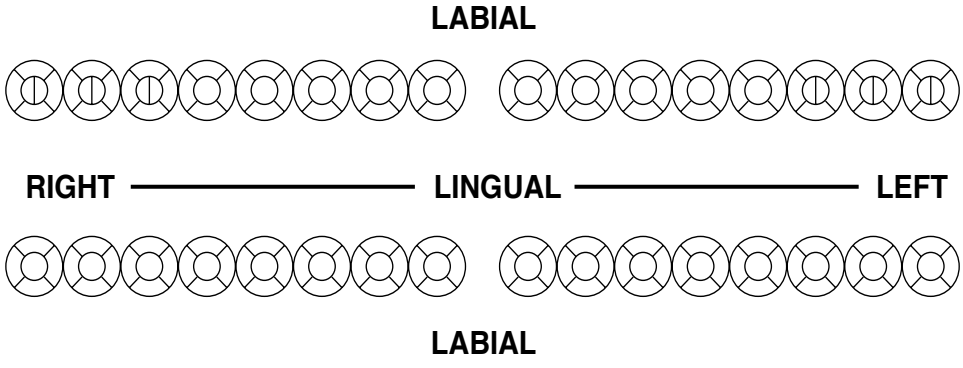
1. In your opinion, is the condition caused by an accident? Yes ☐ No ☐

   If yes, please specify if the treated tooth was sound natural prior to the accident. Yes ☐ No ☐

2.

	Treatment Date	Treatment Provided	No. of Tooth	Charges
(a)				
(b)				
(c)				
(d)				
(e)				
(f)				

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



Name of Dentist: _____

Address: _____

_____

_____

Telephone No.: _____

E-mail: _____

_____

Signature of Dentist with Stamp

Date: _____

Please attach all invoices and other relevant documents.