

Claim form for dental treatment reimbursements

Please complete clearly in **BLOCK CAPITALS**.

Are you submitting this claim as a scanned copy? Yes No

One form must be completed for each patient, for each dental condition treated.

Sections A to D and section F have to be completed by the patient or the main member on behalf of the patient if the patient is a dependant under the age of 18. Section E has to be completed by the patient's dental practitioner.

Further information about how to complete this form can be found on the reverse.

Failure to complete all sections of this form may result in delays.

Section A: Patient details

| | | | | | | | |
|---|--|-----------|--|--|----------|--|--|
| Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms | | | | Other: | | | |
| Family name (surname): | | | | First name(s): | | | |
| Date of birth (dd/mm/yyyy): | | | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| Member number: | | | | Plan number: | | | |
| Correspondence address: | | | | | | | |
| Town: | | Postcode: | | | Country: | | |
| Email: | | | | | | | |
| | | | | | | | |
| Daytime phone: | | | | Evening phone: | | | |

Section B: Main member details (if different from section A)

| | | | | | | | |
|------------------------|--|--|--|----------------|--|--|--|
| Family name (surname): | | | | First name(s): | | | |
| Member number: | | | | Plan number: | | | |

Section C: Claim details

Detail the symptoms/dental condition that the patient received treatment for:

Is this claim for a dental checkup? Yes No

Provide the breakdown of the invoices being submitted with this claim:

| Date of treatment (dd/mm/yyyy) | Invoice date (dd/mm/yyyy) | Invoice reference | Amount (including currency) |
|--------------------------------|---------------------------|-------------------|-----------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Use a separate sheet if you need more space.

Does the patient have another insurance plan or policy that covers dental costs? Yes No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer:

Is the claim as a result of an accident? Yes No

If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space:

Section C: Claim details (continued)

If the patient has suffered an injury as the result of an accident, are they claiming from a third party? Yes No

If 'Yes', provide the other insurer's details including the name and the plan number below:

Section D: Data Protection and Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18**Data Protection Notice**

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the Personal Data Protection Act 2010.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

The policyholder consents to the processing of the personal data provided to the insurer and the transfer of such personal data to other Archipelago Life Insurance Limited entities for the purposes of performance of the contract, such personal data shall be governed by the personal data protection laws of that country. The policyholder is responsible to ensure that all data provided to the insurer are accurate at all times and is obliged to inform the insurer of any changes.

Your information may also be used for the detection and prevention of fraud and for audit purposes. Archipelago Life Insurance Limited works with other insurance providers, regulatory bodies and law enforcement organisations to prevent and detect fraud.

We will not disclose any such information outside of the Company, including any third parties working on our behalf, except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:

Relationship:

Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the patient in the past, or is attending me/the patient at present, to give any details that may be asked for by the insurer or any authorised administrator.

I confirm that I give explicit consent (on behalf of myself and any family members specified in this form) for Archipelago Life Insurance Limited to process our personal information with respect to our membership.

I authorise and request any hospital, specialist, physician or other health provider to furnish Archipelago Life Insurance Limited or its duly authorised agent acting on Archipelago Life Insurance Limited's behalf with such information as Archipelago Life Insurance Limited or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of Archipelago Life Insurance Limited considering this claim.

I do (not)* wish to see a copy of any medical report before it is sent to Archipelago Life Insurance Limited. (*Delete the word NOT if you wish to see a copy of the medical report before it is sent to Archipelago Life Insurance Limited).

Patient's/member's signature:

Date (dd/mm/yyyy):

Section E: Dental treatment – must be completed by the dental practitioner

1. Contact and registration details

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|------|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|
| Name of dental practitioner: | | | | | | | | | | Qualifications: | | | | | | | | | |
| Phone: | | | | | Fax: | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy): | | | | | | | | | | | | | | | | | | | |

2. Symptoms

a) Provide full details of the symptoms presented:

b) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition? Yes No
 If 'Yes', specify the dental/gum/orthodontic condition:

c) On what date did the patient first notice these symptoms (dd/mm/yyyy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yyyy)?

3. Treatment

Complete the dental chart by using the abbreviations below:

| Dental chart | | | | | | | | | | | | | | | | | | |
|--------------|-------|----|----|----|----|----|----|----|------|----|----|----|----|----|----|----|----|-----------|
| | Right | | | | | | | | Left | | | | | | | | | |
| Treatment | | | | | | | | | | | | | | | | | | |
| Finding | | | | | | | | | | | | | | | | | | |
| Upper jaw | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 28 | Upper jaw |
| Lower jaw | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 38 | Lower jaw |
| Finding | | | | | | | | | | | | | | | | | | |
| Treatment | | | | | | | | | | | | | | | | | | |

- | | | | | |
|---|---|--|---|---|
| <p>Finding: b = bridge c = crown ca/da/dn = caries/decay/dental necrosis cl = calculus g = gap closure gb = gingival bleeding gi = gingivitis</p> | <p>gs = gingival swelling i = implant in = inlay m = missing tooth p = periodontis pu/od = pulpitis or odontitis</p> | <p>Treatment: AF = amalgam filling CF = composite filling D = denture E = extraction I = implant IN = inlay</p> | <p>M = metal ceramic crown NB = new bridge NC = new crown O = orthodontics ON = onlay OR = oral radiograph</p> | <p>PR = panoramic radiograph RB = replacement bridge RC = replacement crown RCT = root canal treatment S&P = scale and polish</p> |
|---|---|--|---|---|

4. Breakdown of costs

| Invoice reference | Treatment (itemised) | Amount (including currency) |
|-------------------|----------------------|-----------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

5. Declaration

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

| | |
|----------------------------------|-----------------|
| Dental practitioner's signature: | Practice stamp: |
| Date (dd/mm/yyyy): | |

Section F: Payment details

Have you personally had to pay costs for the treatment that you are claiming for? Yes No

If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the patient if they are 18 or over;
- the planholder if the patient is under 18 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the patient is the main member and is under 18.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the patient's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account: Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

2. Foreign draft

Name to appear on the draft: Currency of the draft:

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and your dental practitioner do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.

Section A – Patient details

- If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the patient is a member under the age of 18, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

Section C – Claim details

- If you have another insurance plan or policy that covers you for medical costs, we will need to know the details as it may affect the amount we pay in respect of your claim.

Sections D and E

If the declarations have not been read and signed, we will not be able to process your claim.

Section F – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue foreign drafts to banks based in Qatar.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

No-claims discount

The no-claims discount applies to individual and family plans only. Claims made under the dental benefit will affect your no-claims discount.

The no-claims discount does not apply to groups.

Deductibles

Any applicable excesses and co-insurances will be deducted from any reimbursement.

Checklist

There are two ways to send your claim to us:

1. By post – check you have included:

- a fully completed Claim form with signed and dated declarations
- original itemised invoices

Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.

2. By email – have you read the scanned claims acceptance criteria?

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at www.interglobalpmi.com

Please call us on +603 6201 0899 or email claims@archipelagolife.com if you require any further assistance.

Send your claim to: Claims Team, Archipelago Life Insurance Limited, B-08-07 Gateway Corporate Suites, Gateway Kiaramas, No 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. W www.archipelagolife.com F +603 62010481

Whenever coverage provided by any insurance policy would be in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, we cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

All plans are underwritten by Archipelago Life Insurance Limited and administered by Aetna Global Benefits (UK) Limited, registered in England (Company Registration No. 03554885), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 312279), Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT, United Kingdom. Archipelago Life Insurance Limited is licensed by Labuan FSA, Company No. LL09829, Licence No. IS2013141. Registered office address: Level 1, Lot 7, Block F, Saguking Commercial Building, Jalan Patau-Patau, 87000 Labuan FT, Malaysia.