SINGAPORE LIFE LTD.
DENTAL CLAIM FORM
SUPERIOR PLAN

SINGAPORE LIFE LTD.
Group Life & Health Claims
4 Shenton Way, #01-01 SGX
Centre 2 Singapore 068807
Tel: 6827 8030
Company Registration
No.196900499K

CLAIMS PROCEDURES

FOR MEMBER **WITH** MEMBERSHIP CARD INDICATING 'DENTICARE'

(1) Present your Membership Card when registering at the clinic.

(2) Complete Part A, B & C – Section 1 of this claim form. The same form with charges should be checked and signed by you after the consultation.

FOR MEMBER **WITHOUT** MEMBERSHIP

(1) Your employer and yourself must complete Section 1of this form respectively.

(2) Give the completed form to the clinic before consultation. The same form with charges should be checked and signed by you after your consultation.

FOR DENTAL PRACTITIONER

(1) To complete Section 2 of this form (turn overleaf).

(2) Please refer to the 'Denticare Claim Procedure' for details.

(3) For patient present with **Membership Card**, no payment needs to be made by the patient at the clinic for all benefit listed in this form. Reimbursement made by Singapore Life Ltd. to the clinic will be in accordance to the 'Schedule of Dental Benefit'

SECTION 1: TO BE COMPLETED BY POLICYHOLDER & INSURED PERSON

PART A: TO BE COMPLETED BY EMPLOYEE & / OR DEPENDANT

1) Name of Insured Person (Employee)	NRIC /Passport No.	Marital Status	Date of Birth (DD/MM/YY)	Gender ☐ F ☐ M
Email Address	Contact No	Occupation		
2) Name of Patient (If patient is dependant)	NRIC /Passport No.	Marital Status	Date of Birth (DD/MM/YY)	Gender ☐ F ☐ M
Relationship to Insured Person ☐ Spouse ☐ Child		Occupation		

PART B: EMPLOYEE'S BANK DETAILS

For reimbursement directly into your bank account, please provide your bank details below. If the designated account provided differs from our record, please contact Singapore Life Ltd. or your service broker/agent for "Change of Bank Account" form to effect the change.

Note: Payment will not be made to employee unless prior agreement was made by employer with Singapore Life Ltd.

Bank Name Branch Code Bank A/C No. | | | | | | | | | | | | | | | | | | | |

PART C: MEDICAL INFORMATION AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 21 years of age)

I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.

I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institution.

I/We understand that Singlife has the right to:

- Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.
- Reject claims, recover amounts paid or impose additional charges, if the claim is false or where there are multiple claims made.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Policy which may be found at http://www.singlife.com/pdpa. Singlife's Data Protection Policy may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

Signature of Employee	Signature of Patient (if patient is dependant)	Date (DD/MM/YY)

PART D: TO BE COMPLETED BY EMPLOYER

1) Date of Employment (DD/MM/YY)	2) Effective date of his/her insurance (DD/MM/YY)	3) Eligible for Benefit under Plan (Please tick one)
		(A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K)

Signature of Employee	Signature of Patient (if patient is dependant)	Date (DD/MM/YY)

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SECTION 2: TO BE COMPLETED BY DENTIST

DESCRIPTION OF BENEFITS	CODE	NO. OF TOOTH	AMT (S$)	DESCRIPTION OF BENEFITS	CODE	NO. OF TOOTH	AMT (S$)
1. Consultation & Oral Exam	A01			8. Periodontal Treatment Root Planning a) Per Tooth b) Subject To Per Quadrant	 H01 H02	 	
2. X-Rays a) Periapical Film b) Bite-wing (each) c) Occlusal Film d) Orthopantograph	 B01 B02 B03 B04	 	 	9. Pulp/Root Canal Treatment (Inclusive of Temporary Fillings/Dressing) a) Pulp Capping b) Root Canal Treatment i. One Canal ii. Two Canals iii. Three Canals	 I01 I02 I03 I04 I05	 	
3. Scaling & Polishing	C01			10. Miscellaneous Treatment a) Analgesics (Oral Only) b) Antibiotics (Oral Only) c) Administration of LA (Excluding Extraction & Oral Surgery)	 J01 J02 J03	 	
4. Amalgam Restoration a) One Surface b) Two Surfaces c) Three Surfaces d) Retentive Pin	 D01 D02 D03 D04	 	 	11. Preposthetic Alveoplasty	K01		
5. Tooth – Coloured Restoration a) One Surface b) Two Surfaces c) Three Surfaces	 E01 E02 E03	 	 	12. Dentures a) Acrylic Complete Upper b) Acrylic Complete Lower c) Acrylic Immediate Denture (Additional Cost to Denture) d) Acrylic Immediate Denture i. Base only ii. Per tooth e) Metal Partial Denture i. Base only ii. Per tooth	 L01 L02 L03 L04 L05 L06 L07	 	
6. Extraction (Inclusive of LA) a) Anterior Tooth b) Posterior Tooth	 F01 F02	 	 	13. Crowns (Exclude Precious Metals)	M01		
7. Oral Surgery (inclusive of LA) a) Incision and Drainage b) Excision of Hyper Plastic Tissue, cyst c) Surgical Root Removal (per tooth) d) Surgical Removal of Wisdom Tooth (Soft Tissue) e) Surgical Removal of Wisdom (Simple Bony Impaction)	 G01 G02 G03 G04 G05	 	 	14. Surgical Removal of Wisdom Tooth (Complicated Bony Impaction)	N01		

DATE SERVICE PERFORMED :	**TOTAL AMOUNT**	**$**
	GST AMOUNT (IF GST REGISTERED)	**$**
	TOTAL AMOUNT CHARGED	**$**

PATIENT DECLARATION (PARENT IF PATIENT IS A MINOR)

I confirm that I have received the above treatment and authorize the release of any information relating to my treatment

PATIENT'S SIGNATURE

DENTIST DECLARATION

I hereby certify that the service listed above have been performed on the above named patient on the date indicated.

DENTIST'S SIGNATURE

CLINIC STAMP