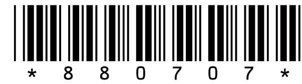

AVIVA LTD
DENTAL CLAIM FORM
SUPERIOR PLAN

AVIVA LTD
Group Life & Health Claims
4 Shenton Way, #01-01 SGX Centre 2
Singapore 068807
Tel: 6827 8030 Fax: (65) 6827 7705
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 Aviva 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 Aviva 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 Aviva 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 Aviva Ltd 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 Aviva Ltd. 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 consent to Aviva (and Aviva 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), my/our insurance coverage and/or managing my/our relationship with Aviva.

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

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html

__________________	__________________	__________________
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	Company's Name & Stamp	Date (DD/MM/YY)

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SECTION 2: TO BE COMPLETED BY DENTIST

DESCRIPTION OF BENEFITS	AVIVA CODE	NO. OF TOOTH	AMT (S$)	DESCRIPTION OF BENEFITS	AVIVA CODE	NO. OF TOOTH	AMT (S$)
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