MSIG Insurance (Singapore) Pte. Ltd.
4 Shenton Way, #21-01 SGX Centre 2
Singapore 068807
Tel +65 6827 7888
Co. Reg. No. 200412212G GST Reg. No. 20-0412212G
msig.com.sg

Dental Claim Form

Policy Number	

Please note that this form is issued without admission of liability. Please state all relevant information requested as complete and as accurate as possible.

Particulars of Insured

Name of Insured (As in NRIC/Passport)*		NRIC/Passport/BC Number*	Gender ☐ Male ☐ Female
Home Address			Date of Birth (dd/mm/yyyy)
Contact Person+			Occupation
Contact Number (H)	(O)	(HP)	Email

+If applicable *Delete if not applicable

Details of Claim

DENTAL CONDITION / INJURY

Nature of Dental Condition / Injury and Final Diagnosis	

Date Symptoms First Started (dd/mm/yyyy) Date First Treated (dd/mm/yyyy)

Attending Doctor's Name and Address

Has the condition been treated previously? ☐ Yes ☐ No
If Yes, please state Name and Address of the Dentist for previous treatment:

Date of previous treatment (dd/mm/yyyy):

OTHER INSURANCE OR COMPENSATION

Was a third party involved? ☐ Yes ☐ No
If Yes, please state whether reimbursement or other compensation will be provided.

Is the Insured/Claimant claiming from another Insurance Company/other sources? ☐ Yes ☐ No
If Yes, please provide a copy of their settlement details.

Supporting Documents

1. Original final detailed hospital bills or receipts
2. Original final clinic bills or receipts

Medical Authorisation (This Portion Must Be Completed By The Claimant)

I hereby authorise any hospital physician or other person who has attended or examined me to furnish to the Insurer or its representative any and all information on my illness, injury, medical history, consultations, prescriptions or treatment, with copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of Claimant

Name of Claimant

Mode of Payment

My preferred way to receive payment is:

☐ PayNow

Name of Account Holder	NRIC / FIN /UEN Number

☐ Credit to my Bank Account

Name of Account Holder (as in Bank Account)			NRIC / FIN / UEN Number
Bank Name	**Bank Code**	**Branch Code**	**Bank Account Number (Please key in numbers only and omit any dashes '-')**

☐ By Cheque

Name of Payee

Declaration

I/We declare that the information given is true and correct to the best of my/our knowledge and belief. I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and I/we shall forfeit my/our rights to claim under the policy.

Signature of Insured	Name	Date (dd/mm/yyyy)

MEDICAL REPORT

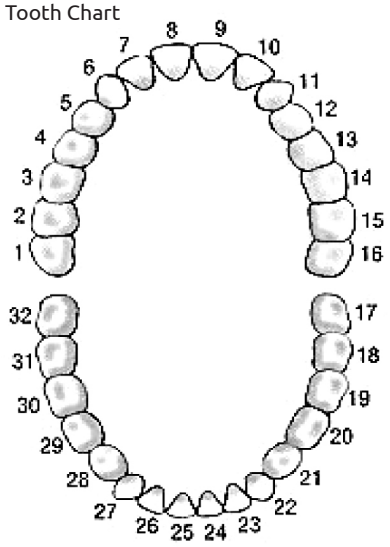
The Claimant must obtain at his/her own expense the medical report from his/her Medical Attendant.

TO BE COMPLETED BY ATTENDING DENTIST / SURGEON

Name of Patient	NRIC/Passport/BC Number*
Treatment date(s) (dd/mm/yyyy)	Date condition / injury was first diagnosed (dd/mm/yyyy)
Final Diagnosis (Based on ICD, 1975 Revision, WHO) of sickness* or extent of injury	ICD Code

What is the cause of the sickness / injury?

Tooth Chart



*mark fillings by shading
*mark extraction with "X"
*mark root canal with "R"

TABLE OF DENTAL TREATMENT DETAIL (use additional pages if necessary)

Date	Procedure Code	Tooth #	Quadrant	Surface	# of Surfaces	Clinic Billed	Covered Amount

How long had the patient been troubled by symptoms prior to the diagnosis?

In your medical opinion, how long do you think the condition existed prior to your diagnosis?

Did the patient have any symptoms prior to consulting you? ☐ Yes ☐ No
If Yes, please indicate the nature of the Symptoms and date Symptoms first started (dd/mm/yyyy):

Are you the patient's usual Dentist? ☐ Yes ☐ No	When did patient first consult you for this condition?

Nature and Date of Treatment rendered (dd/mm/yyyy)

Were the teeth natural and free from decay, defects or prior restorations/appliances at the time of treatment? ☐ Yes ☐ No
If No, describe the condition of the teeth and the procedures or treatment rendered.

Date the procedures or treatment rendered (dd/mm/yyyy)

Signature of Dentist	Name and Address of Clinic/Hospital
Name/Designation	Date (dd/mm/yyyy)

*Delete if not applicable