# Great Eastern

## **GROUP DENTAL CLAIM FORM**

## **CLAIM SUBMISSION PROCEDURES**

#### Please read carefully before

- 1. The Great Eastern Life Assurance Company Limited (The Company) does not admit liability by the mere issue of this Form.
- 2 Please pay the dentist after your treatment and ask the dentist to complete Part II of the Claim Form.
- 3. Please submit the Claim Form and all claim documents (see below) within 30 days from incurring the expenses.
- 4. Please submit only **original final itemised bills** (not summarized bills) and receipts. Photocopies of bills/receipts are **NOT** acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.

DENTAL CODES				
Consultation & Preventive	Code	Medication	Code	
Oral Examination	A1100	Analgesics - oral only	M1000	
Prophylaxis	A1200	Antibiotics - oral only		
Fluoride Treatment	A1300	Administration of Local Anaesthesia		
		Sedative dressing	M1100	
Endodontics				
Pulp Capping	B1100	Periodontics		
Root Canal Therapy (inclusive of temporary filling)		Root Planning Per Tooth	P1100	
Single Canal	B1200	Root Planning Per Quadrant	P1200	
Two Canals	B1300			
Three Canals	B1400	Surgical Extractions		
		Surgical removal erupted tooth	S1000	
Crown (excluding cost of precious alloy)		Surgical removal tooth roots	S1100	
Crown - Provisional Only	C1100	Surgical removal impacted tooth (Simple)	S1200	
Crown - Metal Full	C1200	-soft tissue		
Crown - Porcelain Full	C1300	Surgical removal impacted tooth (Difficult)	S1300	
Crown - Porcelain bonded to metal crown	C1400	-completely bony		
Crown - Recementation	C1500	Surgical removal impacted tooth (Complicated)	S1400	
		-completely bony with unusual surgical approach		
Dentures				
Acrylic Complete Upper	D1000	Radiographs		
Acrylic Complete Lower	D1100	Periapical Film	X1000	
Acrylic Immediate Upper	D1200	Bite-Wing	X1100	
Acrylic Immediate Lower	D1300	Occlusal File	X1200	
Acrylic Partial Denture (Including Base)		Orthopantograph	X1300	
-Per Tooth	D1500			
Metal Partial Denture (Including Base) -Per Tooth	D1700	Restorative (Filling only)		
Diagnostic Plaster Cast		Amalgam Restorations:-	R1100	
Diagnostic i laster Gast	Q1000	Amalgam - one surface	R1200	
Extractions		Amalgam - two surfaces  Amalgam - three & more surfaces	R1200	
Anterior Tooth	E1000	Amaigam - timee & more surfaces	111300	
	E1100	Composite Posteration:		
Posterior Tooth	E1100	Composite Restoration:- Composite Resin - one surface	R2200	
Preprosthetic Alveoloplasty		Composite Resin - two surfaces	R2300	
Alveoloplasty	F1000	Composite Resin - three & more surfaces	R2400	
		Retention Pins	R2500	
Inlay/Onlay - Metal Composite		Hotomaon i ino	112000	
Porcelain (Basic fee excluding precious alloy)		All claimants are to note that the benefits listed here are	e used as a reference	
One surface	I1600	guide for the dentist to complete the Claim Form. The precise terms and		
Two surfaces	11700	benefits are governed by the Master Policy issued to the F	Policyholder.	
Three surfaces	11800			
	_			

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**Important Note:** Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.

#### GROUP DENTAL CLAIM FORM



PART I - STATEMENT BY POLICYHOL	DER (EMPLOYER)						
Name of Employer (Policyholder):  Employee Plan *Please state to whom benefit payment should be made							
		· ·	to:	beneni payment should be made			
Policy No:			Employer	Employee			
			Employer	•			
Name of Employee (Insured Member):		NRIC/Passport No:		Sex:			
			Mal	e Female			
	<u>                                     </u>						
Name of Patient:	NRIC/Passport No:	Relationship	to	Sex:			
		Insured Mem	ber: Mal	e Female			
		Spouse	Child				
Email Address:							
For Payments by GIRO: Please complete the Employee's Bank Account below.							
Name of Bank Bra	anch of Bank Bank	Account Number	Account Ho	Ider's Name			
Important Notes:							
	nt as the Company will not allow creditng to any o		atha Baril Account to	T			
, ,	amages, costs, losses or expenses as a result of	,		above.			
<ul> <li>c. The Company will continue to credit all future/</li> <li>d. Please note that GIRO payment applies to ba</li> </ul>	further claim benefits to the above Bank Account	, unless otherwise notified by the Poli	cynolaer/⊨mployee.				
Authorised Signatory & Date:	Name of Authorised Signatory :	Company's S	Stamp:				
	]		•				
PART II - REPORT BY DENTIST							
TO BE COMPLETED BY Examination & Treatment							
ATTENDING DENTIST		Examination a free	zanone				
	List Tooth Order Usin	g Chart System	Date Service				
് ക്കിന്റെ പ			Performed				
12 11 21 22	Tooth no or, ProcedureC	Please describe procedure (if	_	Fee (\$)			
Ø. "a@@a"."@	Ltr Surface ode	not listed overleaf)	Day Month Year				
( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )							
917 954 34 00 27 00 00 00 00 00 00 00 00 00 00 00 00 00	?						
(D) 16 (C) 55 Lingual 65 (D) 28 (C)	<sup>′</sup> . <del>                                   </del>						
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Q 1 Q 1	δ						
(C) ** (C) ** (C) ** (C) **	<b>,</b>						
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
Identity missing teeth with X							
Surface F facial L lingal							
O occlussal D distal M mesial	.						
	•		Total fee charged				
Dentiet Declaration							
Dentist Declaration I hereby certify that the service listed above have been performed on the abovementioned patient on the dates indicated.							
and the second designation of the second des	,	The second of th	-				
Signature of Doctor/Surgeon	Na	me, Address and Qualification o	f Doctor/Surgeon				
Date :							
PART III - DECLARATION BY PATIENT	•	A MINOR)					
a. I agree to the treatment and the fee c	•	at at any large 1. 1					
C	d answers are true and complete to the be						
c. I hereby authorise Great Eastern Life to disclose and/or to obtain from any Insurance Company any & all information with respect to this or any related claim.							
d. I hereby authorise any hospital, medical practitioner, clinic or any other person who has medically attended to or examined me or my eligible dependent to disclose to Great Eastern Life all medical records or information with respect to any illness or injury, medical history, consultations, prescription or treatment and copies of all heavital records.							
hospital records.  e A photostat copy of this authorisation shall be considered as effective and valid as the original.							
By providing the information set out above, I agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my personal data, and disclosing such personal data to							
the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or settle my							
	claims. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at https://www.greateasternlife.com/sg/en/privacy-and-security-						
policy.html and which I confirm I have read and understood.							
Date : Signature of Patient/Insured Member :							
* nlease tick in the appropriate hoves				Page 2/2			