Administered by:

CG | BRITCAY

HEALTH SERVICES AUTHORITY
CAYMAN ISLANDS
Caring People. Quality Service.

DENTAL CLAIM FORM

Claim No. _____

Group Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_KY@cgcoralisle.com or via Fax to 345 945 0658.

PART 1 To be completed by the EMPLOYEE/RETIREE (please print)

Full Name of Employee/Retiree _____

Effective and/or Termination Date (DD/MM/YY) _____ Certificate No. _____

Employer Name Health Services Authority Group No. 039001-

Employer's Mailing Address _____ Tel. No. _____

Full Name of Patient _____

Patient's Mailing Address _____ Tel. No. _____

Patient's Date of Birth (DD/MM/YY) _____ Patient's Gender ☐ Male ☐ Female

Relationship to Employee/Retiree ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If the Patient has other Dental Insurance coverage, provide name of policy holder and policy number _____

Please indicate if the Patient's condition was the result of: a. ☐ a work-related accident b. ☐ an auto accident
c. ☐ other accidental injury d. ☐ the fault of another party

If you ticked any boxes a. to d., please give the date of the accident (DD/MM/YY) _____

and attach a statement with details indicating when, where and the manner in which the injury ocurred.

DECLARATION:

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions, to furnish full information including full copies of records regarding this claim to British Caymanian Insurance Agency Ltd. or Coralisle Medical Insurance Company Ltd.

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF BENEFIT:

☐ I hereby authorise payment of the Group Insurance Benefit directly to the Dentist named below for amounts otherwise payable to me.

Patient's or Authorised Person's Signature _____ Date _____

PART 2 To be completed by the ATTENDING DENTIST (please print)

Name of Dentist _____

Address of Dentist _____

Dentist Society or T.I.N. (if applicable) _____ Dentist Licence No. (if applicable) _____

Specialist in ☐ Orthodontics ☐ Endodontics ☐ Oral Surgery ☐ Periodontics ☐ Other _____

Date of first visit in this current series _____ Dentist Tel. No. _____

TREATMENT DETAILS

1. Are any services covered by another plan? ☐ Yes ☐ No Details _____
2. Are radiographs or models enclosed? ☐ Yes ☐ No Details _____
3. If Prosthesis, is this the initial replacement? ☐ Yes ☐ No If No, give date of prior replacement _____
4. Is this treatment for orthodontics? ☐ Yes ☐ No If Yes, date service commenced _____

   Date appliances placed _____ Months of treatment remaining _____
5. Please tick and fill in amount: ☐ Statement of ACTUAL charges or ☐ Pre-treatment ESTIMATE of charges = _____

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DENTAL CLAIM FORM

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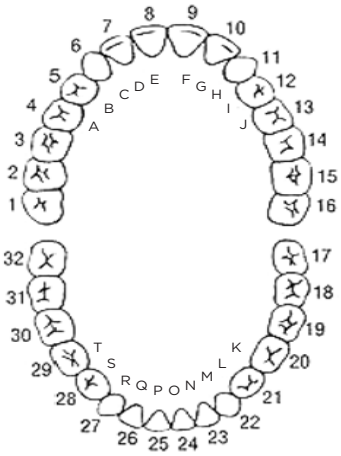

NOTES:

1. Examination Details to be completed on chart below.
2. Identify missing teeth with "X" on dental plan to right.
3. If services cannot be completed within 90 days from date of examination, patient must obtain a new authorisation and claim form for uncompleted services.
4. A pre-operative and post-operative x-ray of root canal work is required. Post-operative bite-wing x-rays must be provided when requested by British Caymanian or Coralisle Medical Insurance Company Ltd.

PART 3 EXAMINATION AND TREATMENT PLAN

List in order from tooth no. 1 through no. 32, using chart system shown

TOOTH No. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (Include x-rays, prophylaxis, materials used, etc.)	DATE OF SERVICE (DD/MM/YY)	PROCEDURE NUMBER	FEE	OFFICE USE ONLY

MAXIMUM ALLOWABLE		TOTAL FEE CHARGED	
DEDUCTIBLE			
BALANCE			
CO-INSURANCE			
CARRIER PAYS*			

*Covered expenses on "Carrier Pays" are authorised. Payment will be made provided the treatment is performed while the patient is covered as per "Effective and/or Termination Date". Payment will be subject to all limitations and maximums.

PART 4 DENTIST'S CERTIFICATION FOR SERVICES PROVIDED

I have been paid. ☐ Yes ☐ No I certify the above items (no. of items_____) were provided and completed by me.

Dentist Signature _____ Date _____

PART 5 DECLARATION (To be signed by the Patient AFTER all the work is complete.)

I hereby certify that the procedures as indicated by "Date of Service" have been completed to my satisfaction.

Patient Signature _____ Date _____

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
PO Box 74, Grand Cayman, KY1-1102 Cayman Islands | Tel 345 949 8699 | Fax 345 945 0658 | www.CGCoralisle.com

Health Insurance and Employee Benefits

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