Dental Care Claim Form

1. Policyholder Information

Full Name

Policy Number

Date of Birth

Contact Number

Address

2. Patient Information

Patient Name

Relationship to Policyholder

Select

Date of Birth

3. Dental Care Information

Date of Treatment

Dentist/Clinic Name

Type of Dental Service

Details of Treatment

4. Claim Details

Amount Claimed

Receipt Number

Is the treatment covered by any other insurance?

Select

5. Declaration

I hereby declare that the above information is true and correct to the best of my knowledge.

Signature

Date