Gulf Insurance &Reinsurance | gig GULF INSURANCE GROUP

Dental Claim Form

To be completed by Employee / Patient

POLICY NO. _____ POLICYHOLDER NAME: _____

Principal's Name : _____

Patient's Name : _____ Membership No. : _____

Please tick relation to Employee / principal: Wife ☐ Husband ☐ Child ☐

Is the cost of this treatment also covered by any other Insurer? YES ☐ NO ☐

Was the treatment as the result of an accident? YES ☐ NO ☐

If the answer to either question is YES, please give full details.

TOTAL CLAIM AMOUNT ☐ CURRENCY ☐

I hereby claim for costs of treatment and declare that, to the best of my knowledge and belief, all information given in support of this claim is true and complete.

Group Member's Signature : _____ **Date :** _____

PART 2 **To be completed by treating Doctor / Speciatlist**

Date of Commencement of illness: _____

Date of first treatment : _____

Type of treatment	Amount	Type of treatment	Amount
1. Extraction	.....	8. Filling	.....
2. Neurectomy	.....	9. Gum treatment	.....
3. X-ray	.....	10. R.C.T.	.....
4. Cleaning	.....	11. Scaling	.....
5. Bridge	.....	12. Orthodontics	.....
6. Dentures	.....	13. Crown	.....
7. Restoration	.....	14. Prophylaxis	.....

Other treatment (s) (Please specify the nature) : _____

Medicines prescribed : _____

_____

Doctor / Specialist's Signature & Stamp **Date**

Notes:

1.- All original prescriptions filled and signed by the treating physicians (photocopies of supporting documents are not acceptable).
2.- photocopy of insurance card is required
3.- Claims have to be submitted no later than 60 days of the start of covered medical treatment.
4.- claims will be reimbursed within 21 days of Company's receiving full documents.
5.- Amounts not supported by orginal documents will not be considered as part of your claim.
6.- X-Ray has to be submitted with dental claims