Dental Claim Form

Section A (to be completed for all claims)

Policy/Member Information

Name of Patient:

US Citizen: ☐ No ☐ Yes, SSN:

Policyholder Name:

Policy Number:

Member Number:

Address:

Country:

Telephone (H): (O)

Fax: Email:

Claim Settlement

Total Amount Claimed:

Payment Method:

☐ Cash Collection (in VND and up to VND 20,000,000 only)

☐ Telegraphic Transfer (VND Account)

Account Name:

Bank Account No.:

Bank Name:

Bank Address:

Sort/Swift Code:

If this claim pertains to an accident:

Date, time, and exact place of accident:

Briefly describe how this accident occurred:

Was a third party involved? If yes, please describe his/her part in this accident, and state whether reimbursement or other compensation will be provided.

Declaration

I hereby declare that all information provided on this form and the documents submitted herewith are true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.

Authorization for Release of Information

I authorize any dentist, doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to the Insurer ("the Company") any information or records they may have regarding my health, tests or treatments I have received, and benefits or compensation therefor. If this claim relates to an accident, past or present, I also authorize any governmental body, agency, or other person or organization that may have records pertaining to such accident to release such records or information. I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organization(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.

Signature of Member
(parent if minor)

Date

Important

☐ Have you completed Section A?

☐ Have you signed the Declaration and Authorization for Release of Information?

☐ Have you enclosed all original bills, statements, receipts, and any other supporting documents?

☐ Has the dentist completed and signed Section B?

Please send completed form and all original bills, statements, receipts, and other documents to:

GlobalHealth Vietnam Company Limited
Suite 12A, 4th Floor, Saigon Center
65 Le Loi, District 1, Ho Chi Minh City, Vietnam
Telephone: (848) 3827 0251 / 3827 0228
Fax: (848) 3822 5454

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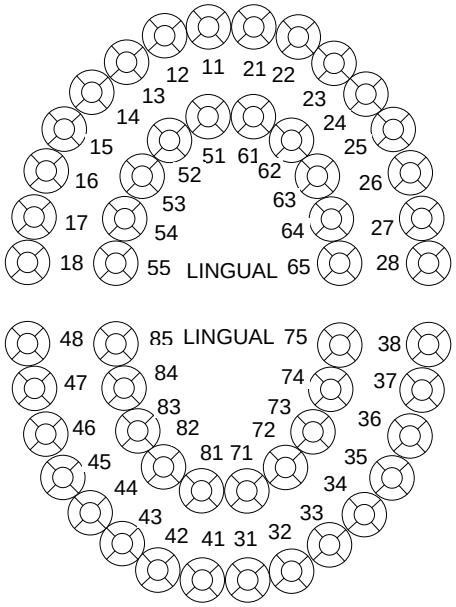
Section B (To be completed by the Attending Dentist at the Insured Person's Expense)

1. Please complete the tooth chart for dental services.

2. In case of accident or injury, please answer 2a and 2b.
   (a) Were teeth natural and free from decay, defects, or prior restoration/appliances at the time of the accident?
   ☐ Yes ☐ No (please explain)

   (b) Was accident in any way connected with the patient's employment or job duties?
   ☐ No ☐ Yes (please explain)

Tooth Chart



Directions

1. Mark fillings by shading in the appropriate space
2. Mark extractions with "X"
3. Mark crowns with a "C"
4. Mark bridges with a "B"

Itemization of Services

Tooth	Surface	Description of Services	Date	Fee

Name and Address of Dentist

Signature of Dentist

Date

AIG GlobalHealth