Guardian Group

Guardian Life of The Caribbean Limited

Arranged by Alliance Insurance Services Limited

DENTAL CLAIM FORM – FOR GROUP MEMBERS

Employee's Name:		**I.D. #**	
Group Name:		**Group #**	**Telephone#**
Group Address:	**Employee's Address**	**Date of Birth:** *MM/DD/YY*	
		Effective Date of Policy: *MM/DD/YY*	

THIS CLAIM IS FOR: MYSELF ☐ SPOUSE ☐ DEPENDANT ☐

DEPENDANT INFORMATION

Dependant's Name:		**Relationship to Employee:**	**Date of Birth:** *MM/DD/YY*
Is there any other dental coverage? ___ **If yes, please explain.**			
For an injury:	**Date of injury:**	**Where did the injury occur?**	
Yes ☐	**MONTH / DAY / YEAR**	**How did the injury happen?**	
No ☐	**Was it related to employment? Yes No If yes, explain:**		
For sickness:	**Date of first symptoms:**	**If a doctor was consulted state the name and address:**	
Yes ☐	**MONTH / DAY / YEAR**		
No ☐	**Please give details of exam.**		

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, Underwriters, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony.

I hereby authorize the release to and use by the Underwriters of Guardian Life of the Caribbean of any medical or other information needed in the processing of this claim and certify that the above information is correct. A copy of this authorization is as valid as the original.

Signed: **Date:** *MM/DD/YY*

Alliance Insurance Services Limited
P O Box PW5236
The D'Image Complex
Rock Farm, Anguilla AI 2640

Tel : (264) – 498 - 7788

E-mail:info@aisanguilla.com

Employee's Name:	I.D. #:	Cert #:
Patient's Name:	Patient's Date of Birth: *MM/DD/YY*	Patient's Relationship to employee

Name of Dentist:	Tel. #:	Fax. #:
Dentist's Address:		

Is patient covered by any other plan? If yes, explain.	Is any of the treatment for Orthodontic Purpose?
Yes ☐ No ☐	Yes ☐ No ☐
Was treatment as a result of an accident?	**Was it an occupational injury?**
Yes ☐ No ☐	Yes ☐ No ☐
Date of Patient's First Visit (Current Series) *MM/DD/YY*	**If Prosthesis, is this initial placement? Yes ___ No ___**

Examination and Treatment Record – List in Order from Tooth No. 1 through Tooth No. 32

Tooth No. or Letter	Surfaces	DESCRIPTION OF SERVICES Including X – Rays, Prophylaxis Materials used, etc.	Date Service Performed MM	DD	YY	Procedure Number	Fee

Orthodontics (Give diagnosis, class of malocclusion and describe appliance (s) in above treatment action)

Date first appliance inserted

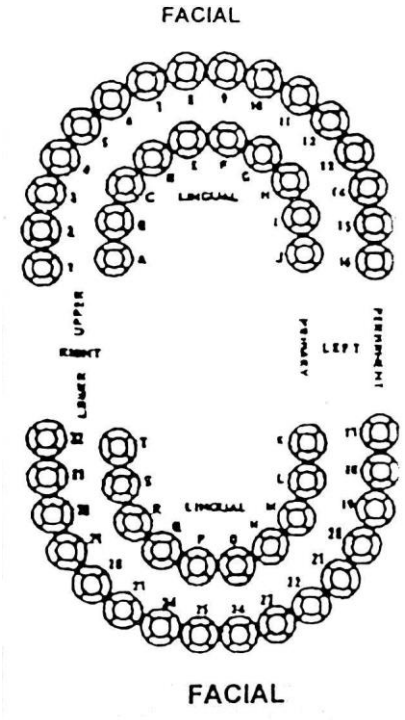
Date last appliance removed _____

Treatment period (number of months) _____

Total Fee ($) _____

Total Fee Actually Charged

Please Indicate missing teeth with an X



I hereby certify that I have received from Mr./ Mrs./ Ms. _____ **the amount of**

_____ **For services rendered and listed above.**

DENTIST SIGNATURE _____ **LICENSE NO.** _____

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization.

EMPLOYEE'S SIGNATURE _____ **DATE** _____