LLOYD'S

CARIB CARE FORM - MEDICAL INSURANCE

Arranged by Caribbean Insurers (Health) Limited, Lloyd's correspondent, underwritten by certain syndicates at Lloyd's

DENTAL CLAIM FORM – FOR GROUP MEMBERS

Employee's Name:		I.D. #
Group Name:		Cert. #
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?	
	MONTH	DAY	YEAR		
Yes ☐				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:	
	MONTH	DAY	YEAR		
Yes ☐					
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 programme, files a statement of claim containing any false or misleading information is guilty of a felony.

I hereby authorise the release to and use by the Underwriters at Lloyd's 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 authorisation is as valid as the original.

Signed: Date: MM/DD/YY

TO BE COMPLETED BY EMPLOYER

Name of Policy Holder:	Policy #: Effective Date: Termination Date:		
Claimant's Name:	THE CLAIMANT IS THE		
	EMPLOYEE ☐	EMPLOYEE'S SPOUSE ☐	EMPLOYEE'S DEPENDANT ☐
Group Administrator's Name	Group Administrator's Signature		Date: MM/DD/YY

Caribbean Insurers (Health) Limited
P O Box 129, Road Town

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Tortola, B.V.I **E-mail: cihl@caribbins.com**

CIHL 09/01/00

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

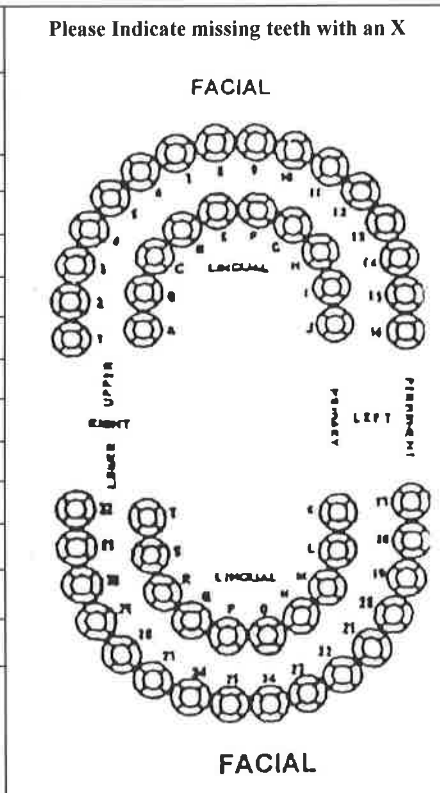
Name of Dentist:	Tel. #:	Fax. #:
Dentist's Address:		

Is patient covered by any other plan? If yes, explain. Yes ☐ No ☐	Is any of the treatment for Orthodontic Purpose? Yes ☐ No ☐
Was treatment as a result of an accident? Yes ☐ No ☐	Was it an occupational injury? 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			Procedure Number	Fee
			MM	DD	YY		
						Total Fee Actually Charged	

Please Indicate missing teeth with an X



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 ($) ____________________

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 authorise 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 resposible for any charges not covered by this authorisation.

EMPLOYEE'S SIGNATURE ____________________ DATE ____________________