PACIFIC CROSS
excellence at every contact

DENTAL CLAIM FORM

(All sections must be completed)

Please send all claims and inquiries to: **Pacific Cross Insurance Company Limited c/o International Services Pacific Cross**
Chaze Plaza Tower 19th Floor, Jl. Jend. Sudirman Kav. 21 Jakarta 12920, Indonesia
Tel: +62 21 2598 9878 Fax: +62 21 2598 9879
E-mail:claim@pic-indo.com Website: http://www.pacificcross.co.id

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient		Sex
Date of Birth (MM/DD/YY)	Member No.	Policy No.
If group insurance, name of the Policyholder		

SECTION B – STATEMENT BY THE PATIENT

1. If any of the above treatments or services were necessitated as a result of an accident, please state the occurrence of the incident.

2. When and where did the accident occur?

3. Was the accident of nature requiring report to the police? If so, was the accident reported? Yes ☐ No ☐
   When and where was it reported?

SECTION C – AUTHORIZATION & DECLARATION

I hereby authorize any hospital or dentist or other person who has attended me to furnish to **PACIFIC CROSS INSURANCE COMPANY LIMITED** (or its representative) and permit the said insurance company (or its representative) to review any and all information requested with respect to any illness, or accident, dental history, consultation, prescription or treatment and copies of all hospital or dental records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostat copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

_____ _____

Date *Signature of Patient (or Parent if a minor)*

Please Turn Over

SECTION D – ATTENDING DENTIST'S REPORT

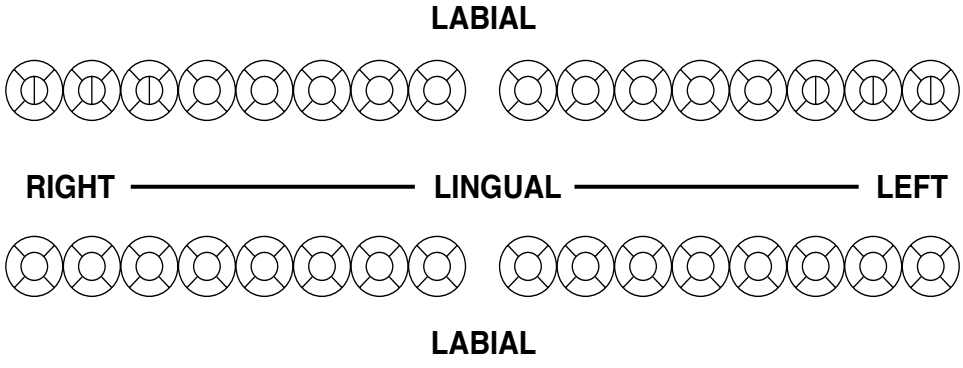
1. In your opinion, is the condition caused by an accident? Yes ☐ No ☐

   If yes, please specify if the treated tooth was sound natural prior to the accident. Yes ☐ No ☐

2.

	Treatment Date	Treatment Provided	No. of Tooth	Charges
(a)				
(b)				
(c)				
(d)				
(e)				
(f)				

Please mark teeth treated or area of oral treatment on the following chart:



Name of Dentist: _____

Address: _____

_____

_____

Telephone No.: _____

E-mail: _____

_____

Signature of Dentist with Stamp

Date: _____

Please attach all invoices and other relevant documents.