



TOKIO MARINE  
INSURANCE GROUP

## GROUP DENTAL CLAIM FORM

Dear insured employee / spouse or child (“life insured”),

We refer to your claim for dental reimbursement.

In order for us to process your claim, we require the following:

- (1) Group Dental Claim Form (to be completed by life insured)
- (2) Original medical invoices / receipts / bills

Please complete all questions in the form for prompt settlement of the claim.

Once we have received all the above required documents, we will process your claim accordingly.

All the required documents must be forwarded to our company within 30 days from the date of consultation.



## GROUP DENTAL CLAIM FORM

### IMPORTANT NOTES:

- (1) The issue of this claim form is not an admission of liability
- (2) Tokio Marine Life Insurance Singapore Ltd. ("TMLS") reserves the right to request for additional medical reports when it deems necessary
- (3) This form is to be completed by the life insured

Name of employer: \_\_\_\_\_ Group Policy No.: \_\_\_\_\_  
Name of employee: \_\_\_\_\_ Date of employment: \_\_\_\_\_  
NRIC / Passport No.: \_\_\_\_\_ Gender:  Male  Female  
Date of birth: \_\_\_\_\_ Marital status: \_\_\_\_\_  
Designation: \_\_\_\_\_ Plan: \_\_\_\_\_

### DETAILS OF PATIENT (IF DIFFERENT FROM EMPLOYEE)

Name of patient: \_\_\_\_\_  
Relationship to employee: \_\_\_\_\_  
NRIC / Passport No.: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Gender:  Male  Female

### DETAILS OF CLAIM

Type of dental treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Declaration

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted.

### Personal Data Notice

I agree and consent that TMLS may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or TMLS's Data Protection Policy available at [www.tokiomarine.com](http://www.tokiomarine.com), which I have read, understood and agreed to the same.

\_\_\_\_\_  
Signature of Life Insured \_\_\_\_\_ Date (dd/mm/yyyy)

Contact No(s) : \_\_\_\_\_ Email : \_\_\_\_\_