



Singapore Life Ltd.  
DENTAL CLAIM FORM

Singapore Life Ltd.  
Group Life & Health Claims  
4 Shenton Way, #01-01 SGX Centre 2  
Singapore 068807  
Tel: 6827 8030  
Company Registration No. 196900499K

(Patient is required to pay the dentist and attach receipt to seek reimbursement from Singapore Life Ltd.)

SECTION I – TO BE COMPLETED BY THE EMPLOYEE			
Name of Company		Policy Number	
Commencement of employment (DD/MM/YYYY)	Market unit/Department	Daytime Contact Number	
Name of Patient	NRIC/BC/FIN No. of Patient	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (DD/MM/YYYY)
Name of Employee (If the patient is not the employee)	NRIC/BC/FIN No. of Patient	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (DD/MM/YYYY)
Relationship <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Son <input type="checkbox"/> Daughter	All reimbursements will be credited into your payroll's bank account, please furnish your bank account detail only if there are recent changes to your bank account.		
Office email address (if available)	Name of Bank	Branch Name / Branch Code	Account Number

**MEDICAL INFORMATION AUTHORISATION**

I/We hereby authorise Singapore Life Ltd. ("Singlife") to request from any hospital, physician, person or organisation, all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records concerning the patient at any time and authorise the prior mentioned organisations to disclose all such information to Singlife. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We hereby authorise Singlife to request from any hospital, physician, person or organisation, all information with respect to any.

I/We declare and undertake that I/we have submitted the actual bills and receipts (including electronic/digital copies) issued by the medical institutions.

I/We understand that Singlife has the right to:

1 Ask for originals/certified true copies of the bills and receipts, or contact the medical institution directly, to confirm that the bills and receipts are original.

1 Reject claims, recover amounts paid or impose additional charges, if the claims is false or where there are multiple claims made.

I/We declare that the statements and answers stated are true and complete to the best of my/our knowledge and belief.

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Policy which may be found at [www.singlife.com/bdga](http://www.singlife.com/bdga). Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

**SECTION II – TO BE COMPLETED BY THE DENTIST**

Date of Treatment (DD/MM/YY) <input type="text"/>	Singapore Life Ltd. Office Code	No. of Tooth Treated	Amount Incurred	Others (please indicate tooth number)	Amount Incurred
<b>TYPE OF TREATMENT</b>					
1. Consultation / Examination	A01				
2. Scaling and Polishing	C01				
3. X-rays					
i) Periapical	B01	_____	_____		
ii) Bite Wing	B02	_____	_____		
iii) Occlusal Film	B03	_____	_____		
iv) Orthopantograph	B04	_____	_____		
4. Amalgam Restoration					
i)	D01	_____	_____		
ii) 2 Surfaces	D02	_____	_____		
iii) 3 Surfaces	D03	_____	_____		
5. Tooth Colored Restoration					
i)	E01	_____	_____		
ii) 2 Surfaces	E02	_____	_____		
iii) 3 Surfaces	E03	_____	_____		
6. Extraction of Tooth (inclusive of LA)					
i) Anterior Tooth	E01	_____	_____		
ii) Posterior Tooth	E02	_____	_____		
7. Oral Surgery (inclusive of LA)					
i) Incision & Drainage	G01	_____	_____		
ii) Excision of Hyper Plastic Tissue, Cyst	G02	_____	_____		
iii) Surgical Root Removal (per root)	G03	_____	_____		
iv) Surgical Removal of Wisdom Tooth (Soft Tissue)	G04	_____	_____		
v) Surgical Removal of Wisdom Tooth (Simple Bony Impaction)	G05	_____	_____		
8. Periodontal Treatment Root Planning					
i) Per Tooth	H01	_____	_____		
ii) Per Quadrant	H02	_____	_____		
9. Pulp/Root Canal Treatment					
i) Pulp Capping	I01	_____	_____		
ii) Root Canal - 1 Canal	I02	_____	_____		
2 Canals	I03	_____	_____		



Singapore Life Ltd.  
DENTAL CLAIM FORM

Singapore Life Ltd.  
Group Life & Health Claims  
4 Shenton Way, #01-01 SGX Centre 2  
Singapore 068807  
Tel: 6827 8030  
Company Registration No.196900499K

10. Miscellaneous Treatment					
i) Analgesics (Oral Only)	J01	_____	_____		
ii) Antibiotics (Oral Only)	J02	_____	_____		
iii) Administration of local Anesthesia	J03	_____	_____		
<b>TOTAL</b>					
Name of Dentist					
DENTIST'S SIGNATURE & CLINIC'S STAMP				DATE	

Note : -

1. Section I is to be completed by Employee.
2. Section II is to be completed by DENTIST.
3. Employee to pay the dentist after treatment and attached your receipt together with the completed claim form and submit to:-

Singapore Life Ltd.  
Group Life & Health Claims  
4 Shenton Way #01-01  
SGX Centre 2  
Singapore 068807

4. To expedite reimbursement, please provide your bank account for direct credit into your account. A payment advice will be sent upon credit to your bank account.