



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.



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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, which I have read, understood and agreed to the same.

Signature of Life Insured _____ Date (dd/mm/yyyy) _____

Contact No(s) : _____ Email : _____