InterGlobal
An Aetna Company

Claim form for dental treatment reimbursements

Please complete clearly in BLOCK CAPITALS. **Are you submitting this claim as a scanned copy?** ☐ **Yes** ☐ **No**

One form must be completed for each patient, for each dental condition treated.

Sections A to D and section F have to be completed by the patient or the main member on behalf of the patient if the patient is a dependant under the age of 18. Section E has to be completed by the patient's dental practitioner.

Further information about how to complete this form can be found on the reverse.

Your claim will be processed by Aetna Global Benefits (UK) Limited on behalf of the insurer. Failure to complete all sections of this form may result in delays.

Section A: Patient details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:
Correspondence address:	
Town:	Postcode: Country:
Email:	
Daytime phone:	Evening phone:

Section B: Main member details (if different from section A)

Family name (surname):	First name(s):
Member number:	Plan number:

Section C: Claim details

Detail the symptoms/dental condition that the patient received treatment for:

Is this claim for a dental checkup? ☐ Yes ☐ No

Provide the breakdown of the invoices being submitted with this claim:

Date of treatment (dd/mm/yyyy)	Invoice date (dd/mm/yyyy)	Invoice reference	Amount (including currency)

Use a separate sheet if you need more space.

Does the patient have another insurance plan or policy that covers dental costs? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer:

Is the claim as a result of an accident? ☐ Yes ☐ No

If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space:

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Insurance Brokers Ltd.
Unit 8E Golden Sun Centre 223 Wing Lok St Sheung Wan HK
Tel. (852) 2530 2530 Fax (852) 2530 2535
Email: crew@navigator-insurance.com www.navigator-insurance.com

Section C: Claim details (continued)

If the patient has suffered an injury as the result of an accident, are they claiming from a third party? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name and the plan number below:

Section D: Data Protection, Access to Medical Reports and Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18

The words 'Aetna' and 'other Aetna entities' mean Aetna Global Benefits (UK) Limited and include any other Aetna International Inc. group company as the context requires.

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the UK Data Protection Act 1998, medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Aetna entities and/or third parties acting on our behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, your personal data will be protected by a strict code of security which we and any third parties working on our behalf are subject to and will only be used in accordance with our instructions.

Your information may also be used for the detection and prevention of fraud and for audit purposes. Aetna works with other insurance providers, regulatory bodies and law enforcement organisations to prevent and detect fraud.

We will not disclose any such information outside of the Company, including any third parties working on our behalf, except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	Relationship:

Access to Medical Reports Act 1988

In order to process your claim, we may need to apply for a medical report from any medical practitioner that has attended you. We will require your consent before we can apply for this.

Under the law, you can:

1. Give your consent. If you choose this option, your medical practitioner will send the report direct to us.
2. Request to see the medical report before it is sent to us. If you choose this option, we will notify the medical practitioner of your request when we apply for your records. You must contact your medical practitioner within 21 days of our notifying you that we have requested a medical report about you to make arrangements to see the report. If you fail to make contact within 21 days, the medical practitioner will be entitled to send the medical report direct to us. You also have a right to request the correction of any information you believe is misleading or incorrect. After you have seen the report, you must give your consent before the medical practitioner can release the report to us.
3. You have a right to withhold your consent. Please note that if you choose this option, we may be unable to accept or process your claim.

You have a right to ask your medical practitioner for any report (whether or not you had previously requested to see it) we have requested within six months of its having been supplied to us. Your medical practitioner is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your medical practitioner may also charge you for any of these services.

Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this medical claim I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the patient in the past, or is attending me/the patient at present, to give any details that may be asked for by the insurer or any authorised administrator.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for Aetna Insurance Company Limited (the insurer) to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

(Our full terms and conditions and details of our privacy policy can be found at www.interglobalpmi.com)

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or its duly authorised agent acting on its behalf with such information as the insurer or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the insurer considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988.

I do (not)* wish to see a copy of any medical report before it is sent to the insurer. (*Delete the word NOT if you wish to see a copy of the medical report before it is sent to the insurer).

Patient's/main member's signature:	Date (dd/mm/yyyy):

Section E: Dental treatment – must be completed by the dental practitioner

1. Contact and registration details

Name of dental practitioner:	Qualifications:
Phone:	Fax:
Email:	
Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy):	

2. Symptoms

a) Provide full details of the symptoms presented:

b) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition? ☐ Yes ☐ No
If 'Yes', specify the dental/gum/orthodontic condition:

c) On what date did the patient first notice these symptoms (dd/mm/yyyy)?

d) On what date did the patient first present these symptoms to you (dd/mm/yyyy)?

3. Treatment

Complete the dental chart by using the abbreviations below:

Dental chart																	
	Right								Left								
Treatment																	
Finding																	
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw
Finding																	
Treatment																	

Finding:
b = bridge
c = crown
ca/da/dn = caries/decay/dental necrosis
cl = calculus
g = gap closure
gb = gingival bleeding
gi = gingivitis
gs = gingival swelling
i = implant
in = inlay
m = missing tooth
p = periodontis
pu/od = pulpitis or odontitis

Treatment:
AF = amalgam filling
CF = composite filling
D = denture
E = extraction
I = implant
IN = inlay
M = metal ceramic crown
NB = new bridge
NC = new crown
O = orthodontics
ON = onlay
OR = oral radiograph
PR = panoramic radiograph
RB = replacement bridge
RC = replacement crown
RCT = root canal treatment
S&P = scale and polish

4. Breakdown of costs

Invoice reference	Treatment (itemised)	Amount (including currency)

5. Declaration

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

Dental practitioner's signature:	Practice stamp:
Date (dd/mm/yyyy):	

Section F: Payment details

Have you personally had to pay costs for the treatment that you are claiming for? ☐ Yes ☐ No

You must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the patient if they are 18 or over;
- the planholder if the patient is under 18 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the patient is the main member and is under 18.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

☐ 1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the patient's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

☐ 2. Foreign draft

Name to appear on the draft:

Currency of the draft:

Click anywhere on this text to go back to the top of the form.

This form is only compatible with Adobe Reader and can be used on either a PC, Mac, tablet or smartphone device subject to compatibility.

You can use the tab key to navigate to the next field and using shift + tab allows you to go back to the previous field. You can also use the mouse to navigate through the form.

In the boxes marked ' Date ' you need to ensure that the date is typed in (dd/mm/yyyy) format. If your entry is not in this format an invalid message will appear and you will be prompted to re-enter the date correctly.

Please fill in all of the required fields. Once completed you need to print the form off, sign the declaration and scan or post the form back to us in accordance with the instructions on your Claims procedures form.

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and your dental practitioner do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the first treatment date.
- Always send us the original itemised invoices with this form. Photocopies, receipts and credit card statements will not be accepted. The itemised invoices need to detail the following:
  - Patient's name
  - Date of service
  - Diagnosis.
- If you were provided with a sheet from your pharmacist detailing prescribed medication, please attach this to the Claim form.
- We will not refund non-medical costs such as medical reports unless explicitly requested by us. Depending on the condition/loss, we may require further medical, dental or police reports.
- Most mobile phone email addresses cannot receive attachments. Please provide a PC email address if possible.

Section A – Patient details

- If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the patient is a member under the age of 18, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

Section C – Claim details

- If you have another insurance plan or policy that covers you for medical costs, we will need to know the details as it may affect the amount we pay in respect of your claim.

Sections D and E

If the declarations have not been read and signed, we will not be able to process your claim.

Section F – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

i. Ensure that you are able to receive payment in the method and currency you have requested.
ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
v. Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
vi. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.
vii. We cannot issue foreign drafts to banks based in Qatar.
viii. Please note that we are unable to make claim payment reimbursements via bank transfers to Japan Post Banks as they do not accept international remittances.
ix. Japanese banks will often charge for processing a foreign draft. Most Japanese banks will not process foreign drafts in any currency other than Japanese Yen.
x. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

No-claims discount

The no-claims discount applies to individual and family plans only. Claims made under the dental benefit will affect your no-claims discount.

The no-claims discount does not apply to groups.

Deductibles

Any applicable excesses and co-insurances will be deducted from any reimbursement.

Checklist

There are two ways to send your claim to us:

1. By post – check you have included:

- a fully completed Claim form with signed and dated declarations ☐
- original itemised invoices ☐

Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.

2. By email – have you read the scanned claims acceptance criteria? ☐

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at www.interglobalpmi.com

Please call us Toll Free: 0120 76 7703 or email japan-claims@interglobal.co.jp if you require any further assistance.

Send your claim to: Claims Team, InterGlobal Japan Limited, 3F Koike Koraibashi Bldg., 1-3-4 Koraibashi, Chuo-Ku, Osaka, 541-0043, Japan.

Please note that InterGlobal Japan Limited is a service company only and provides local service for Aetna Insurance Company Limited. We do not solicit business, accept premiums, assess or reimburse claims, or issue insurance documents from the Japan service office.

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