



**Health Insurance**

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.  
Please submit completed form via Email to BS\_claims\_admin@cgcoralisle.com or via Fax to 242 326 8189.

**PART 1** To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured \_\_\_\_\_ Dental Plan  Basic  Comprehensive  
 Effective and/or Termination Date (DD/MM/YY) \_\_\_\_\_  
 Group Policy No. \_\_\_\_\_ Certificate/Employee No. \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Transit No. \_\_\_\_\_  
 Employer's Mailing Address \_\_\_\_\_ Tel. No. \_\_\_\_\_  
 Full Name of Patient \_\_\_\_\_  
 Patient's Mailing Address \_\_\_\_\_ Tel. No. \_\_\_\_\_  
 Patient's Date of Birth (DD/MM/YY) \_\_\_\_\_ Patient's Gender  Male  Female  
 Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_  
 If the patient has other Dental Insurance coverage, provide name of policy holder and policy number \_\_\_\_\_

**DECLARATION**

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions, to furnish full information including full copies of records regarding this claim to Atlantic Medical Insurance Company Limited.

Patient's or Authorised Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorise payment of the Group Insurance Benefit directly to the Dentist named below for amounts otherwise payable to me.

Patient's or Authorised Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART 2** To be completed by the ATTENDING DENTIST (please print)

Name of Dentist \_\_\_\_\_  
 Address of Dentist \_\_\_\_\_  
 Dentist Society or T.I.N. (if applicable) \_\_\_\_\_ Dentist Licence No. (if applicable) \_\_\_\_\_  
 Specialist in  Orthodontics  Endodontics  Oral Surgery  Periodontics  Other \_\_\_\_\_  
 Date of first visit in this current series (DD/MM/YY) \_\_\_\_\_ Dentist Tel. No. \_\_\_\_\_

**TREATMENT DETAILS**

1. Please check if treatment is a result of  occupational illness  injury  motor accident  other accident \_\_\_\_\_  
 2. Are any services covered by another plan?  Yes  No If Yes, details \_\_\_\_\_  
 3. Are radiographs or models enclosed?  Yes  No If Yes, details \_\_\_\_\_  
 4. If Prosthesis, is this the initial replacement?  Yes  No If No, give date of prior replacement (DD/MM/YY) \_\_\_\_\_  
 5. Is this treatment for orthodontics?  Yes  No If Yes, date service commenced (DD/MM/YY) \_\_\_\_\_  
 Date appliances placed (DD/MM/YY) \_\_\_\_\_ Months of treatment remaining \_\_\_\_\_  
 6. Please tick and fill in amount:  Statement of ACTUAL charges or  Pre-treatment ESTIMATE of charges = \_\_\_\_\_

