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DENTAL CLAIM FORM

All sections on this form must be filled in completely

POLICY DATA

Policy No	
Policy Holder	
Employee Name	
Address	
Telephone No.	

I the undersigned, hereby declare that the particulars stated in this form are true in every respect. I hereby authorize any physician, clinic, hospital, public health centre, insurance company, legal institution, personal or other organizations that has any records or information on the Insured and health of the Insured whether the Insured was still alive or dead to furnish PT International Services Pacific Cross or its authorized institution, all records/ information regarding the insured person and the condition/ health of the Insured while the Insured is alive or has died. A copy of this statement should be as valid and legal as the original.

Place & Date	Name & Signature

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MEDICAL DATA

Name and address of doctor	
Date of consultation	
Anamneses	
Medical History	
Dental Diagnose	
Treatment	
Medical Therapy	

As the treating doctor of the above-mentioned patient, I hereby state that I have read and answered the questions on this form clearly and completely.

Doctor name	
Address	
Place and date	
Address	
Signature of doctor and stamp of hospital or doctor	