Guardian Group
Guardian Life of The Caribbean Limited

PLAN ☐
PLUS PLAN ☐
FIRST CHOICE PLAN ☐
SMART CHOICE PLAN ☐
GLOBAL CARE PLUS ☐

MEDICAL HEALTH INSURANCE
Arranged by Alliance Insurance Services Limited

TIME LIMIT FOR SUBMISSION OF CLAIMS WILL BE 90 DAYS FROM THE DATE THE EXPENSES WERE INCURRED

DENTAL CLAIM FORM – INDIVIDUAL

PART 1 Insured's and Patient Information

Insured's Name	Certificate/Policy No.	Date of Birth	Sex	I.D. Number
			_ Male __ Female	

Does the Employer provide group insurance:	If yes, is the Patient for this claim covered by the insurance:	Name of Medical Plan	This claim is about
__ Yes __ No	___ Yes ___ No		___ Myself ___ My Spouse ___ My Son (Daughter)

Patient's Name if not the Insured	Date of Birth	Sex
		___ Male __ Female

PART 2 Claims Information

Is this Claim a result of a injury? __ Yes __ No

Date _____ How did it happen? _____

_____

Where did it occur? _____

_____

Was the accident connected with the Patient's Employment?
___ Yes ___ No

Is this Claim a result of sickness? ___ Yes ___ No

When did symptoms begin? _____

When did patient first see a doctor for it? _____

Name of Doctor _____

Address of Doctor _____

_____

PART 3 Other Insurance Information

Is the patient covered by one or more of the following (Include insurance carried by Spouse or other)?

A. Any other group insurance, or any medical plan because of membership in a group?	___ Yes	___ No
B. Any other similar	___ Yes	___ No
C. Any Medical Sponsored by School or College?	___ Yes	___ No
D. Is there coordination of benefits provision in the other group insurance plan?	___ Yes	___ No
E. Any coverage through the Social Security program?	__ Yes	___ No

If the answer of any of the above is "Yes", please give complete information about the plan(s) in space below:

Name and Address of the Other Insurance Company	Name of the Employer, Group or School	Policy Number

PART 4 Authorization for Release of Medical Information

The statements above are true and correct to the best of my belief. I authorise any hospital or physician to supply re-insurers any information requested. Also, I hereby authorise my employer or Underwriters to release to or obtain from any organisation or person or regulatory agency any information, which may be necessary to determine benefits payable under the policy with Underwriters. A photostatic copy of this authorisation shall be considered as effective and valid as the original. Any person who knowingly and with intent to injure, defraud, or deceive Underwriters, files a statement of claim containing any false, incomplete, or misleading information, thereto, commits a fraudulent insurance act, which is a crime subject to criminal prosecution and civil penalties.

Signature of Insured _____ Date _____

PART 5 Authorization for Payment

I hereby authorize payment directly to the hospital indicated on the next page otherwise payable to me. But not exceeding the regular charges of the hospital for this period of hospitalization. I understand that I am financially responsible for any charges not covered by this authorisation.

Signature of Insured _____ Date _____

Employee's Name:	I.D. #:	Cert #:
Patient's Name:	Patient's Date of Birth: *MM/DD/YY*	Patient's Relationship to employee

Name of Dentist:	Tel. #:	Fax. #:
Dentist's Address:		
Is patient covered by any other plan? If yes, explain. Yes ☐ No ☐	Is any of the treatment for Orthodontic Purpose? Yes ☐ No ☐	
Was treatment as a result of an accident? Yes ☐ No ☐	Was it an occupational injury? Yes ☐ No ☐	
Date of Patient's First Visit (Current Series) *MM/DD/YY*	If Prosthesis, is this initial placement? Yes ___ No ___	

Examination and Treatment Record – List in Order from Tooth No. 1 through Tooth No. 32

Tooth No. or Letter	Surfaces	DESCRIPTION OF SERVICES Including X – Rays, Prophylaxis Materials used, etc.	Date Service Performed MM	DD	YY	Procedure Number	Fee

Orthodontics (Give diagnosis, class of malocclusion and describe appliance (s) in above treatment action)

Date first appliance inserted _____

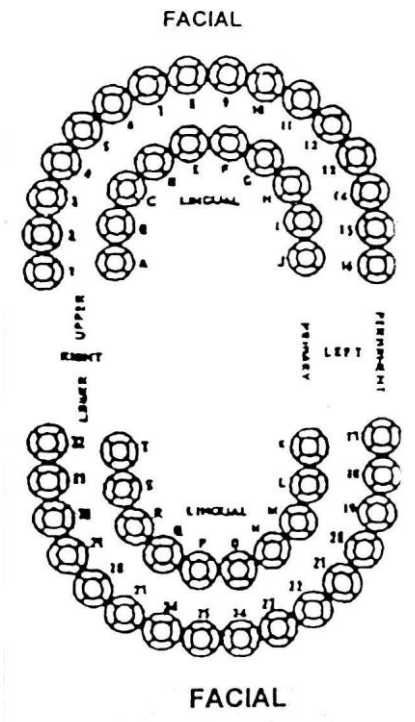
Date last appliance removed _____

Treatment period (number of months) _____

Total Fee ($) _____

Total Fee Actually Charged

Please Indicate missing teeth with an X



I hereby certify that I have received from Mr./ Mrs./ Ms. _____ **the amount of**

_____ **For services rendered and listed above.**

DENTIST SIGNATURE _____ **LICENSE NO.** _____

I hereby authorise payment directly to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above. I understand that I am financially resposible for any charges not covered by this authorisation.

EMPLOYEE'S SIGNATURE _____ **DATE** _____

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