



Claim Form for Dental Treatment Reimbursements

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

The sections marked by an asterisk (*) must be completed in full by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18. Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

Further information about how to complete this form can be found on the last two pages.

* Section 1: Main member/claimant detai	ls						
Title: Mr Mrs Miss Ms	Other:						
Family name (surname):	First name(s):						
Date of birth (dd/mm/yyyy):	Gender: Male Female						
Member ID ¹ :	Plan number:						
Plan sponsor:							
Correspondence address:							
	code: Country:						
Email:							
Daytime phone:	Evening phone:						
¹ as shown on your Member ID card - it could be 6 or 8 digits.							
* Section 2: Patient details (if different from Section 1)							
Title: Mr Mrs Miss Ms	·						
	Other:						
Family name (surname):	First name(s):						
Date of birth (dd/mm/yyyy):	Gender: Male Female						
Member ID ¹ :							

* Section 3: Claim details Detail the symptoms/dental co		eived treatment for	:					
Is this claim for a dental check	kup?	s □ No If 'Y	'es', Section 6 does not	need to be completed.				
Provide the breakdown of the invoices being submitted with this claim:								
Country of treatment	Date of treatment (dd/mm/yyyy)	Invoice date (dd/mm/yyyy)		Invoice amount (including currency)				
Use a separate sheet if you need more space. Total number of invoices								
Does the patient have anothe	r insurance plan or policy t	hat covers dental co	osts?] 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?								
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:								
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 4: Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18								
I declare that, to the best of my knowledge, all the information provided on this Claim form is truthful and correct. I understand that Archipelago Insurance Limited will rely on the information provided as such. I agree and accept that this declaration gives Archipelago Insurance Limited, and its appointed representatives, the right to request past, present, and future medical information in relation to this claim, or any other claim related to the member/covered individual, from any third party, including providers and medical practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred (worldwide) to any organization within the Aetna group, its suppliers, providers and any affiliates.								
Patient's/main member's signature: Date (dd/mm/yyyy)								

* Section 5: Payment details								
Do you need us to pay the provider directly? Yes No								
If 'Yes', we can only make payment to the provider if their bank details are included on the invoice.								
Have you personally had to pay costs for the treatment that you are claiming for? Yes No								
If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft or cheque', and completing the required information.								
If another person or entity has paid on your behalf please give their name:								
Please tick one of the following as applicable								
☐ Use Recurring Reimbursement Election (RRE) information currently on file								
☐ Use the bank information provided in this section as your permanent RRE								
☐ Use the bank information provided below only for expenses related to this claim								
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 claimant's name (as given in Section 1) is different to the account holder name, please provide the following details: Address of account holder:								
Email:								
Telephone number of account holder:								
Relationship to the claimant:								
Bank account details:								
Bank name:								
Bank address (including town/city and country):								
BIC/SWIFT code: Payment currency:								
Currency of bank account:								
Account number:								
To help us direct your payments efficiently, supply the following as relevant:								
IBAN (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 or cheque								
Name to appear on the draft or cheque:								

Currency of the draft or cheque: ___

Section 6: Dental treatment – must be completed by the dental practitioner																	
1. Contact	1. Contact and registration details																
Name of	dental	practitio	ner: _														
Qualifica	tions: _																
Tax Iden	tificatio	n Numb	er (red	quired '	for prov	iders pi	ract	ising in t	he US):								
Phone: _																	
Address:																	
Г	Town: Postcode: Country:																
Email:																	
Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy):																	
2. Symptor	ns																
a) Provide f	ull deta	ails of th	e sym	otoms	present	ed to y	ou:										
b) Provide f	ull deta	ails of th	e clinic	al find	lings on	examir	nati	on and n	ote them	on th	e chart	below:					
Dental char	t							Pe	rmanen	t teeth							
Treatment																	
Finding																	
Upper jaw	18	17	16	15	14	13		2 11	21	22	23	24	25	26	_	28	Upper jaw
Lower jaw Finding	48	47	46	45	44	43	4	2 41	31	32	33	34	35	36	37	38	Lower jaw
Treatment																	
Dental char	t							De	ciduous	s teeth	1						
Treatment																	
Finding																	
Upper jaw		55	5	54	53	52		51	61	62		63	6	64	65	Upper jaw	
Lower jaw		45	4	14	43	42		41	71	72		73	74		75	75 Lower jaw	
Finding																	
Treatment								Tue etee	4-								
Finding: b =	bridge		gs	; =	gingival	swellin	ıa	Treatm AF = a	ent: amalgam		M =	metal	ceram	nic F	PR = r	oanorai	mic
c =	crown		i =	=	implant		•	f	illing			crowr	1		r	adiogra	aph
ca/da/dn =	a/da/dn = caries/decay/ in = inlay dental necrosis m = missing tooth					CF = c	е		new bridgenew crown			RB = replacement bridge RC = replacement crown					
cl =	calculu		5 III		periodo				illing denture		0 =		dontics				nal treatment
g = gap closure pu/od = pulpitis or E = extraction ON = onlay S&P = scale and polish																	
gb = gingival bleeding odontitis I = implant OR = oral																	
gi = gingivitis IN = inlay radiograph c) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition?																	
If 'Yes', specify the dental/gum/orthodontic condition:																	
d) On what date did the patient first notice symptoms of the dental condition (dd/mm/yyyy)?																	
e) On what date did the patient first present these symptoms to you (dd/mm/yyyy)?																	
3. Diagnosis																	
- 																	

(continued)

Section 6: Dental treatment – must be completed by the dental practitioner (continued)

4. Breakdown of costs						
Invoice reference	Treatment (include the number of surfaces if any restoration was done and the number of canals if any RCT was done)	Invoice amount (including currency)				
5. Declaration						
I declare that to the best of my kn complete.	nowledge and belief the information given in this s	ection of the Claim form is full, true and				
Dental practitioner's signature: _						
Date (dd/mm/yyyy):	Practice stamp:					

How to complete this form

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

Assessment of the claim may be delayed if the patient/main member and the patient's dental practitioner do not complete all the necessary sections of this form.

Sections 1 to 5 must 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 6 must be completed by the patient's dental practitioner unless the claim is for:

• a routine dental checkup

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the dental practitioner. In such circumstances, we will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:

- diagnosis of the dental condition treated
- treatment date
- type of treatment including the tooth number, number of surfaces if restoration work was done and/or number of canals if Root Canal Treatment was done, and
- the dental provider's official stamp

We may need to contact the patient's dental practitioner for more information in order for us to process the claim under the terms and conditions of the policy. We will tell you if we need to do this.

A quick guide on how to submit your claim. For detailed information, please refer to the "Your guide to making a claim" section in your Member Handbook.

Send us the claim within 180 days of the first treatment date. You must send the following items to make sure that we can process your claim:

- the fully completed Claim form
- the original itemised invoice
- the original receipt. We do not accept credit card statements as proof of payment
- a copy of the prescription if you are claiming for medication, and
- a copy of the investigative tests results where relevant (e.g. x-rays, scans).

Important information

Please remember these important points when completing your Claim form.

Section 3 - Claim details

If the patient has another insurance plan or policy that covers him/her for medical costs, we will need to know the details as it may affect the amount we pay in respect of their claim.

Section 4 – Declaration

If the declaration has not been read and signed, we will not be able to process the claim.

(continued)

How to complete this form (continued)

Section 5 – 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, we will only issue payment to:
 - the patient if they are 18 or over
 - the plan holder if the patient is under 18 and is a dependant under the plan, or
 - the parent or legal guardian named as the primary member, if the patient is under 18
- Ensure that you are able to receive payment in the method and currency you have requested.
- 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.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or recipient bank service charges. Please contact your bank for further details.
- 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.
- Payment by foreign draft or cheque 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 or cheque. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- 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 base currency of your plan. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue non-QAR foreign drafts or cheques to members/providers with bank accounts based in Qatar as the banks will not allow those to be encashed.
- 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.
- Whenever coverage provided by any insurance policy is in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Assets Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions

We know you may have guestions and we're always here to help. You can call us any time on the phone number listed on the back of your Member ID Card.

You can also send us a secure email by logging in to www.aetnainternational.com and clicking 'Contact us'.

You can scan your claims to us, rather than post them. It is important that any claim you send to us is done either by scan or originals, but not both.

Send your claim to us

Archipelago Insurance Limited Unit 3A - 25 Labuan Times Square U0350 Jalan Merdeka 87007 F.T. Labuan Malaysia

- For the quickest and most convenient way of submitting your claim, please register for the secure member website at www.aetnainternational.com and submit your claim online.
- Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +65-6395-6747
- Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: AsiaPacServices@aetna.com

Contact us.

For claim related queries please contact our 24 hour Member Services helpline at:

Free from Malaysia 1-800-885-801 Collect or Direct +60-3-7724-4179

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If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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