DENTAL CLAIM FORM

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan. We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

PATIENT'S DETAILS

To be completed by the beneficiary or his/her legal representative

1 Patient name			
2 Policy ID		**3** Patient's date of birth	
4 Full mailing address of patient			
5 State nature of illness			
Email address		Tel no	Fax no
6 Do you have any other health or travel insurance policy for which you may receive full or partial reimbursement for these expenses?	Yes	No	
If you have answered yes in section 6, please give details below:			
Full name		Policy number	
Address of insurance company			

PAYMENT DETAILS

To be completed by the beneficiary or his/her legal representative

7 List of expenses for which reimbursement is claimed and amount			**8** State to whom you wish settlement paid and currency	
Treatment	Date	Amount	Payment to	Currency

9 Select payment method	**Cheque**	**Bank wire transfer**	

10 Should payment be sent to your bank account, please complete the following:

Bank account no.		Bank name	
Sort Code		Name of account holder	
Swift Code*		IBAN*	
Bank branch address:			

11 I authorise the release of any medical information necessary to process this claim. To the best of my knowledge all the details given are true.

I warrant and represent that I have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to you. I confirm that each covered person is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)

Signature of insured person (or Legal Representative):	
Date	

*by providing this information, payment will be transferred more efficiently by the receiving bank

THIS SECTION TO BE COMPLETED BY THE DENTIST

CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
	PREVENTATIVE TREATMENT			
	EXAMINATIONS			
A01	Normal			
A11	Extensive			
A21	Full case assessment			
	X-RAYS			
B01	Bitewing			
B02	Intra oral			
B03	O.P.G.			
	SCALING AND POLISHING			
E01	One visit			
D01	Fissure sealants			
D11	Topical fluoride application			
MOU	Occlusal splint			
	MINOR TREATMENT			
	FILLINGS			
G01	Amalgam - one surface			
G02	Amalgam - two surfaces			
G03	Amalgam - three+ surfaces			
G21	Composite - one surface			
G22	Composite - two surfaces			
G31	Additional charge use of pin			
	ROOT CANAL TREATMENT			
H01	Upper and lower anterior (1 root)			
H02	Upper premolar (2 roots)			
H03	Lower premolar (1 root)			
H04	Molars (3+ roots)			
	EXTRACTIONS			
L01	Single			
L02	Per additional tooth			
N11	Post-operative care			

CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
	MAJOR TREATMENT			
	PERIDONTAL TREATMENT (NON-SURGICAL)			
E21	Prolonged (curettage/root planing)			
F51	Splinting			
	PERIDONTAL TREATMENT (SURGICAL)			
F01	Gingivectomy			
F11	Mucoperio, flap bone surgery			
	DENTURES – METAL/ACRYLIC			
R63	Additional tooth			
R61	Addition of clasp			
K71	Denture repair			
	CROWNS/BRIDGES			
J01	Veneers (per tooth)			
K32	Adhesive bridges			
K41	Conventional bridgework			
K12	Standard post and core			
K11	Gold post and core			
K07	Bonded precious crown			
K05	Bonded non-precious crown			
K08	Full cast crown			
K06	Porcelain crown			
	INLAYS			
K02	Precious			
K01	Non-precious			
K03	Porcelain			
	TOTAL			

I confirm that the treatment has been/will be carried out and I hereby declare that all treatment as stated is being submitted for approval/has been completed.

Dentist's signature:	
Date:	
Dentist's stamp:	

Please return your fully completed form along with the original receipt/invoices to:

Treatment incurred outside the USA send to:

Cigna Global Health Options
1 Knowe Road
Greenock
PA15 4RJ
Scotland

Tel: +44 (0) 1475 788182
Fax: +44 (0) 1475 492113
Email: cignaglobal_customer.care@cigna.com

Treatment incurred inside the USA send to:

Cigna International
PO Box 15964
Wilmington, Delaware 19850
United States of America

Tel: +44 (0) 1475 788182
Fax: 855 358 6457
Email: cignaglobal_customer.care@cigna.com

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing deliberately false information, commits a fraudulent insurance act, which is a crime.

We will not deal with any claims which we believe to be fraudulent. Committing fraud may result in your policy being terminated, or we will investigate any claims which we believe to be fraudulent.

Your relevant Cigna contracting entity from those listed below will be detailed in your Policy Rules and Certificate of Insurance.
a) Cigna Life Insurance Company of Europe S.A-N.V.; or
b) Cigna Global Insurance Company Limited; or
c) Cigna Worldwide General Insurance Company Limited; or
d) Cigna Europe Insurance Company S.A-N.V.