



PROOF OF CLAIM MUST BE SUBMITTED WITHIN 180 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

I 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 Colonial Medical Insurance Company.

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 _____

II 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, 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 = _____

