InterGlobal HealthCare Plans

International Private Medical Insurance

Dental Claim Form

Please complete clearly in block capitals. Information about how to complete can be found on the reverse of this form.
Please call us on Toll free 0120 76 7703 or email japan-claims@interglobal.co.jp if you require any further assistance.

About your claim

Your claim will be processed by InterGlobal Limited on behalf of the insurer. Please enclose the original invoices - photocopies, receipts and credit card vouchers are not acceptable. We are unable to return original documents, but we will be happy to provide certified copies on request.

A Patient details

If the patient is a dependant under the age of 18, the main member must complete sections A to F for the patient.

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐	Other:
Family name:	First name(s):
Date of birth (dd/mm/yy):	Sex: Male ☐ Female ☐
Group name (if applicable):	
Member number:	Plan number:
Correspondence address:	
Town:	Postal code:
Country:	Email:
Daytime telephone:	
Evening telephone:	Fax:

Symptoms/condition needing treatment:

B Main member details (if different from section A Patient details, above)

Family name:	First name(s):
Member number:	Plan number:

C Further information

Does the patient have another insurance policy that covers dental treatment costs?	☐ Yes	☐ No	If yes, please provide details on a separate sheet.
If you have suffered an injury as the result of an accident, are you claiming from a third party?	☐ Yes	☐ No	If yes, please provide details on a separate sheet.
Is your claim as a result of an accident?	☐ Yes	☐ No	If yes, please provide the circumstances of the accident and how it happened on a separate sheet.

D Payment details

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, please tell us how you wish to be reimbursed (please tick one option below). Please note that we will only issue payment to the claimant if they are 18 or over, another dependent on your plan if they are 18 or over, the main member on the plan, or the planholder:

☐ 1. Bank transfer – please complete this information for bank transfer payments (note that this is the quickest and safest method of payment):	
Name of account holder:	Account number:
Currency of bank account:	
Please ensure that you complete the mandatory information required below – failure to do so may result in delays in you receiving the claim settlement and you incurring additional bank charges. a). IBAN number (mandatory for all payments within the EEA (European Economic Area), Kuwait and UAE (United Arab Emirates)).	
Name of your bank:	Address of your bank:
Or	
b). BIC/SWIFT code (mandatory for all other transfers)	
Name of your bank:	Address of your bank:
Also, to help us direct your payments efficiently please also supply as relevant:	
Sort code (mandatory for UK banks): 6 digit number	Routing Code/Branch Code:
ABA number (mandatory for transfers to US located banks): 9 digit number	
RUT (mandatory for CLP (Chilean Peso) transfers):	
☐ 2. Foreign draft:	
Name to appear on the draft:	Currency of the draft:
☐ 3. Credit card. Please specify currency:	
Name (as it appears on card):	Credit card number:
Expiry date (mm/yy):	Card type:

E Claim details

Date of treatment	Invoice date	Invoice reference	Amount (including currency)

F Data Protection Notice and Declaration

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to Law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

We will communicate directly with you about your claim if you are aged 18 or over, or with the main member if you are under 18 unless we are advised otherwise. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below;

I would like information about any claims I may have be provided to:

Name:	Relationship:

Access to Medical Records Act 1988

In order to process your claim, we may need to apply for a medical report from any medical practitioner that has attended you. We will require your consent before we can apply for this.

Under the law, you can:

1. Give your consent. If you choose this option, your medical practitioner will send the report direct to us.
2. Request to see the medical report before it is sent to us. If you choose this option, we will notify the medical practitioner of your request when we apply for your records.

You must contact your medical practitioner within 21 days of our notifying you that we have requested a medical report about you to make arrangements to see the report.

If you fail to make contact within 21 days, the medical practitioner will be entitled to send the medical report direct to us.

3. You have a right to withhold your consent. Please note that if you choose this option, we may be unable to accept or process your claim.

You have a right to ask your medical practitioner for any report (whether or not you had previously requested to see it), we have requested within six months of its having been supplied to us. Your medical practitioner is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your medical practitioner may also charge you for any of these services.

Signed declaration

I declare that all the details given on this claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I am committing a criminal offence and that this will invalidate the plan and make me liable to prosecution. For this dental claim I authorise any dentist, medical practitioner, specialist, consultant or other relevant establishment who has attended me/the patient in the past or is attending me/the patient at present, to give any details that may be asked for by the insurer or any authorised administrator.

I confirm that I give explicit consent, (on behalf of myself and any family members specified in this form) for InterGlobal Limited to process our personal information with respect to our membership and I confirm that I have brought the Notice to the attention of these family members.

Our full terms and conditions and details of our privacy policy can be found at www.interglobalpmi.com

I authorise and request any hospital, specialist, physician or other health provider to furnish InterGlobal Limited or its duly authorised agent acting on InterGlobal's behalf with such information as InterGlobal or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of InterGlobal Limited considering this claim.

Patient's/member's signature:	Date (dd/mm/yy):

G Dental treatment

This section must be completed by the dental practitioner.

Note to the dental practitioner: Please give this form back to the patient after you have completed it.

Practice stamp:

1. Contact details

Name of dental practitioner:		Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐
Qualifications:	Email:	
Telephone number:	Fax number:	
Email:		

2. Registration details

How long has the patient been registered with you/the clinic/the hospital?

Please provide dates (dd/mm/yy):

3. Symptoms

a) Was the patient suffering from dental pain when they first visited you? ☐ Yes ☐ No

b) Has the patient suffered from the same or similar symptoms before? ☐ Yes ☐ No

If yes, please provide dates:
c) On what date did the patient first notice these symptoms (dd/mm/yy)?
d) On what date did the patient first present these symptoms to you (dd/mm/yy)?
e) Please provide full details of the symptoms needing treatment:

4. Treatment

a) In your opinion, was the dental treatment: ☐ Routine? ☐ Emergency?

b) Please complete the dental chart by using the abbreviations below:

Dental chart																	
	Right								Left								
Treatment																	
Finding																	
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw
Finding																	
Treatment																	

Finding:
b = bridge
c = crown
ca/da/dn = caries/decay/dental necrosis
cl = calculus
g = gap closure
gb = gingival bleeding
gi = gingivitis
gs = gingival swelling
i = implant
in = inlay
m = missing tooth
p = periodontis
pu/od = pulpitis or odontitis

Treatment:
AF = amalgam filling
CF = composite filling
D = denture
E = extraction
I = implant
IN = inlay
M = metal ceramic crown
NB = new bridge
NC = new crown
O = orthodontics
ON = onlay
OR = oral radiograph
PR = panoramic radiograph
RB = replacement bridge
RC = replacement crown
RCT = root canal treatment
S&P = scale and polish

If the treatment was NC or RC, was a precious or semi-precious metal used? ☐ No ☐ Yes If yes, what?

If the treatment was IN or ON, was a precious or semi-precious metal used? ☐ No ☐ Yes If yes, what?

5. Breakdown of costs

Invoice reference	Treatment (itemised)	Amount (including currency)

6. Declaration

I declare that to the best of my knowledge and belief the statements made on this claim form are full, true and complete.

Dental practitioner's signature:	Date (dd/mm/yy):

Important information

Please remember these important points when completing your claim form:

- Assessment of your claim may be delayed if you and your dental practitioner do not complete all the necessary sections of this form.
- Complete one form per dental condition, per person.
- Return this form to us within six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.
- Make sure that you complete sections A to F and that all dentists who have treated you complete section G.

Section A – Patient details

- If the patient is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the patient is under 18 and has their own plan, a parent or legal guardian must complete the form and sign the declaration for them.

Section C – Further information

- If you have another insurance policy that covers you for medical costs, we will need to know the details as it may affect the amount we pay in respect of your claim. Please give the name of the insurance company, the name of the plan holder, the plan and/or member numbers on a separate sheet of paper and submit it to us with your claim form.

Section D – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider direct, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

i) Please ensure that you are able to receive payment in the method and currency you have requested.

ii) 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.

iii) We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.

iv) 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.

v) Payment by foreign draft 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. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.

vi) 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 currency of your plan.

vii) We cannot make payment in the following currencies but if in doubt, please refer to us:

- Chinese Yuan Renminbi (RMB) • Brunei Dollars (BND) • Russian Ruble (RUB) • Venezuelan Bolivares (VEB) • Zimbabwean Dollars (ZWD) • Lebanese Pounds (LBP)

viii) Please note we cannot issue foreign drafts or cheques to banks based in Qatar.

ix) Please note we are unable to make claim payment reimbursements via bank transfer to Japan Post Banks as they do not accept international remittances.

x) Japanese banks will often charge for processing a foreign draft or cheque. Most Japanese Banks will not process foreign drafts or cheques in any currency other than

Japanese Yen.

xi) We are able to settle the claims to the following credit cards and in most currencies:

- Diners
- MasterCard
- Visa

In the event that we are unable to make payment in the currency you have specified, we will contact you to confirm an alternative.

Sections F and G

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

No claims discount (NCD)

The NCD applies to individual and family plans only and not group plans. Any claims made under the wellness benefit or under a benefit on an optional add-on plan will not affect the NCD.

Claims made under all other benefits will affect your NCD.

Excess

If you have an excess on your plan, this will be deducted from any reimbursement.

Checklist

Have you sent us:

- A fully completed claim form with signed and dated declaration? ☐
- Original itemised invoices (copies will not be accepted)? ☐

Send your claim to: Claims Team, InterGlobal Japan Limited, 3F Koike Koraibashi Bldg., 1-3-4 Koraibashi, Chuo-Ku, Osaka, 541-0043, Japan
W www.interglobalpmi.com
InterGlobal Insurance Company Limited is registered in England No. 5956141
Authorised and regulated by the Financial Services Authority