CAYMAN FIRST
FIRST IN INSURANCE. TODAY. TOMORROW.

Form No. GIS06 Aug 10, 2010

# INSURANCE CLAIM FORM FOR DENTAL CARE

## A. CLAIMANT INFORMATION *(To be completed by Insured)*

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Sex: [ ] Male [ ] Female |
| Patient Address: | | Patient Insured Status: [ ] Self [ ] Dependant |
| Enrollee Name: | Member ID: | Dependant Number: |
| Group Policy Number: | Group Name: | |

**CLAIMANT'S AUTHORISATION**

I authorise Cayman First to obtain medical records from any medical service provider, insurer, employer or other source deemed necessary to settle this claim.

Signature _____ Date _____

**PAYMENT ASSIGNMENT**

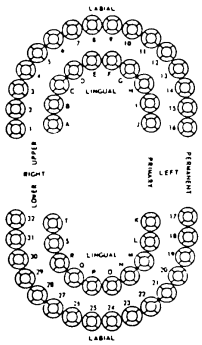
I authorise Cayman First to pay the proceeds of this claim to the undersigned Dental Care Provider.

Signature _____ Date _____

## B. DENTAL CARE SERVICES/ TREATMENT PROVIDED *(To be completed by Dentist/ Dental Surgeon)*

| | | |
|---|---|---|
| Dental Provider Name: | | Telephone No.: |
| Dental Provider Address: | | |
| Was treatment a result of an accident? [ ] No [ ] Yes If Yes, describe: | | |
| If prosthesis, is this the initial placement? [ ] No [ ] Yes If No, explain reason for placement: | | Date of prior placement: |
| Date of first visit for current series: | Is treatment for orthodontics? [ ] No [ ] Yes | For current series, months of treatment remaining |

USE "X" TO INDICATE MISSING TEETH




INDICATE MISSING TEETH WITH AN "X"

**USE TOOTH CHART AT LEFT TO INDICATE TOOTH TREATED**

| DATE OF SERVICE | TOOTH LETTER | TOOTH SURFACE | DENTAL SERVICE | DENTAL CODE | FEE CI$ | INS. CO. USE ONLY |
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I hereby certify that this is a true statement of treatment and services rendered.

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|---|---|---|
| **TOTAL FEES:** | | |
| **PAID BY PATIENT:** | | |
| **BALANCE DUE:** | | |

Signature of Dental Care Provider _____ Date _____

**Cayman First Insurance Company Limited** | Harbour Place | 3rd Floor | 103 South Church Street
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