

Underwritten by:



Administered by:



# AIG Medi-Care Dental Claim Form

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## HOW WE USE YOUR INFORMATION

In relation to the personal information collected in this claim form (or otherwise provided during the course of the claim process, including by way of call recordings), I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG") and/or its service providers, I have informed the individual about the purposes for which his/ her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG and/or its service providers, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG and/or its service providers may collect, use and process my/his/her personal information as follows:

- a) the personal information may be collected, used and disclosed by AIG and/or its service providers to:
- i. process and administer this insurance claim;
  - ii. assess, investigate, adjust and make a decision on this claim;
  - iii. administer my insurance policy (including pursuing recovery from reinsurers or other parties);
  - iv. deal with disputes and complaints,
  - v. respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
  - vi. respond to requests from the policyholder;
  - vii. carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
  - viii. compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
  - ix. manage AIG's infrastructure and business operations; and
  - x. for other purposes stated in AIG's Data Privacy Policy.

b) AIG and/or its service providers may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:

- i. third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
- ii. AIG's agents;
- iii. brokers, my authorised agents or representatives or next-of-kin;
- iv. the policyholder;
- v. legal process participants and their advisors;
- vi. governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
- vii. other financial institutions for the purpose of administering this claim, obtaining policy payments;
- viii. loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers,
- ix. external auditors;
- x. another member of the AIG group (for all of the purposes stated in (a)) in any country; or
- xi. other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at <https://www.aig.sg/privacy>.

## PATIENT'S DETAILS

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

<b>1</b> Patient name					
<b>2</b> Policy ID				<b>3</b> Patient's date of birth	
<b>4</b> Full mailing address of patient					
<b>5</b> State nature of illness					
Email address		Tel no		Fax no	
<b>6</b> 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 of insurance company				Policy number	
Address of insurance company					

## PAYMENT DETAILS

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

<b>7</b> List of expenses for which reimbursement is claimed and amount			<b>8</b> State the currency of payment and who you wish payment to be made to	
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:				
<p>11 I hereby declare that all information provided on this form and the documents submitted herewith is true and correct to the best of my knowledge and belief. The amounts claimed are the actual charges incurred by me, are legally due to me under the terms of this policy, and are not recoverable from any other source.</p> <p><u>Authorisation for Release of Information Clause</u>  I authorise any doctor, hospital, or other health provider or facility, insuring or reinsuring company, or employer to release to AIG Asia Pacific Insurance Pte. Ltd. ("the Company") any information or records they may have regarding my health, tests or treatments I have received, benefits or compensation therefore. If this claim relates to an accident, past or present, I also authorise any governmental body, agency, or other person or organisation who may have records pertaining to such accident to release such records or information.</p> <p>I understand that this information will be used by the Company to determine eligibility for benefits, and that any information obtained will not be released by the Company to any person except to reinsuring companies or other persons or organisation(s) performing business or legal services in connection with my claim, save as may be required by law. I agree that a photocopy or facsimile of this release shall be as effective as the original.</p> <p><b>(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.)</b></p>				
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

PREVENTATIVE TREATMENT				
CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
<b>EXAMINATIONS</b>				
A01	Normal			
A11	Extensive			
A21	Full case assessment			
<b>X-RAYS</b>				
B01	Bitewing			
B02	Intra oral			
B03	O.P.G.			
<b>SCALING AND POLISHING</b>				
E01	One visit			
D01	Fissure sealants			
D11	Topical fluoride application			
MOU	Occlusal splint			

MINOR TREATMENT				
<b>FILLINGS</b>				
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			
<b>ROOT CANAL TREATMENT</b>				
H01	Upper and lower anterior (1 root)			
H02	Upper premolar (2 roots)			
H03	Lower premolar (1 root)			
H04	Molars (3+ roots)			
<b>EXTRACTIONS</b>				
L01	Single			
L02	Per additional tooth			
N11	Post-operative care			

MAJOR TREATMENT				
CODE	TREATMENT	NO OF UNITS	DATE OF TREATMENT	CHARGE TO PATIENT
<b>PERIODONTAL TREATMENT (NON-SURGICAL)</b>				
E21	Prolonged (curettage/root planing)			
F51	Splinting			
<b>PERIODONTAL TREATMENT (SURGICAL)</b>				
F01	Gingivectomy			
F11	Mucoperio, flap bone surgery			
<b>DENTURES – METAL/ACRYLIC</b>				
R63	Additional tooth			
R61	Addition of clasp			
K71	Denture repair			
<b>CROWNS/BRIDGES</b>				
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			
<b>INLAYS</b>				
K02	Precious			
K01	Non-precious			
K03	Porcelain			
				<b>TOTAL</b>
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 copies of the receipt/invoices to: [AIGClaims@cigna.com](mailto:AIGClaims@cigna.com)

For any support submitting your claims, please contact Cigna Healthcare's Customer Care team on:  
 Tel. Within Singapore: +65 6549 3188  
 Tel. WorldWide: +44 1475 333420

**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. We will investigate any claims which we believe to be fraudulent.

AIG Medi-Care is underwritten by AIG Asia Pacific Insurance Pte. Ltd. and administered by Cigna Europe Insurance Company S.A.-N.V. Singapore Branch.

## Need to get in touch?

If you have any questions about your policy, need to get approval for treatment, or for any other reason, please contact Cigna Healthcare's Customer Care team 24 hours a day, 7 days a week, 365 days a year.



### Use your Customer Area

- › Live chat with us
- › Message us
- › Arrange a callback



### Call Us

- › Singapore: +65 6549 3188
- › International: +44 1475 333420



Alternatively, you can email us at: [AIGCustomerCare@cigna.com](mailto:AIGCustomerCare@cigna.com)

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact AIG Asia Pacific Insurance Pte. Ltd. or visit the AIG, GIA or SDIC websites ([www.aig.sg](http://www.aig.sg), [www.gia.org.sg](http://www.gia.org.sg) or [www.sdic.org.sg](http://www.sdic.org.sg)).