



61-62 Avenue of the Republic & Robb Street
Tel: 592-22-58991-3 Fax:592-22-58995

Email: www.demeraramutual.com

DENTAL CLAIM FORM PRINCIPAL'S STATEMENT

(Note: **ALL** questions **MUST be answered** for every claim.
NA = Not Applicable)

Principal's No.: _____ Group Name: _____ Group Number: _____ Claim No: _____

1. Principal's Name _____ Date of Birth: _____ Sex: Female Male

2. Name of Patient _____ Date of Birth: _____ Sex: Female Male

3. Name of Illness or Condition _____ Attending Dentist _____

4. Has the claimant familiarized him/herself with the terms and conditions of the contract for this medical plan? Yes No

5. When did the symptoms of this illness first occur?> D / M / Y NA

6. Was treatment necessary because the patient was injured or poisoned?> Yes No

7. If the patient was injured or poisoned, state the **Date, Time** and **How** the incident occurred. _____ NA

8. Did Patient voluntarily participate in an activity that targeted the patient for abuse or endangerment?> Yes No

9. Is Patient entitled to Workmen Compensation or coverage under any other medical plan?> Yes No

10. If you answer 'Yes' to question 9 above, give name of Company. _____ NA

11. If you answer 'Yes' to question 10 above, has patient made any claim for the relevant benefits?> Yes No NA

12. Check all your receipts submitted for this claim and in the spaces provided below, please write your total expenses for each category.

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 their records) regarding this claim to **Demerara Mutual Life**. I also understand that only original documents are valid in support of my claim and that once submitted, all documents associated with the expense and other relevant circumstances associated with the loss, becomes the property of the Company. I agree to reimburse **Demerara Mutual Life** to the extent of the amount paid on this claim under any Occupational Policy Provision in the event benefits are provided under any Workmen's Compensation Law or similar Legislation. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Principal's Signature _____ Patient's Signature (if over 18yrs) _____

EMPLOYER'S STATEMENT

Employee's Occupation _____ Date Employed _____ AM

If Patient is Employee state the last day of work _____ Hour _____ PM

Has the employee returned to work? Yes When? _____ No When expected? _____

Has the employee made claim for Workmen's Compensation? Yes No Is he/she entitled to such benefits? Yes No

Employer _____ By _____ Date _____ 20 _____

APPLICATION FOR ASSIGNMENT OF COVERAGE BENEFITS

NA

I hereby authorize Demerara Mutual Life to pay to _____ whatever benefits to which I may be entitled with respect to the services rendered to the named patient from _____ 20 _____ to _____ 20 _____ All charges that are not covered by the Medical Plan shall be borne by me.

_____ Date

_____ Principal's Signature

NA

FOR OFFICAL USE ONLY

_____ Date Received

_____ Recipient's Name (PRINT)

_____ Group Administrator's Signature

_____ Title

