



DENTAL INSURANCE CLAIM FORM: ELITE PLAN

Section A: Insured Details

Policy Holder Full Name			
ID Number		Date	
Policy Number		Contact No	
Patient Full Name		Patient ID or Date of Birth	

Section B: Practice Details

Dentist Name			
Date of Visit		Practice no	

Section C: Diagnosis Detail

PLEASE NOTE: Only the benefit claimed for in the [blue section](#) below will be processed and if it is not completed then this claim will be declined automatically. It is also compulsory to submit a valid statement or quote with your claim.

DIAGNOSIS:	Likely Treatment	Cover	Mark with X	Tooth Numbers	Internal Use
Gingivitis	Scale & Polish	R100 per event			GINGIV
Tooth decay or abscess-poor prognosis of rehabilitation	Extraction	R120 per tooth			DECAYP
Tooth decay- good prognosis of rehabilitation	Filling	R250 per tooth			DECAYG
Dental abscess-good prognosis of rehabilitation	Root Canal	R700 per tooth			ABSCES
Impacted tooth	Impacted Tooth Removal	R500 per tooth	(X-rays required)		IMPACT
Severely decayed or damaged tooth	Crown	R2000 per tooth	(X-rays required)		DECAYS
Periodontitis	Gum Surgery	R1500 per event	(X-rays required)		PERIOD

Section C: Declaration by Policy Holder

I understand the contents of the completed claim form and I declare that the information given is, to the best of my knowledge and belief, correct and complete. Furthermore, I also irrevocably authorise any person or institution, dental practitioner, medical practitioner, hospital, nursing institution or medical authority to provide Denis Insurance Administrators (Pty) Ltd with any information that may be required regarding my health.

Policy Holder Signature:

Date.....