Petrotrin

PETROLEUM COMPANY OF TRINIDAD AND TOBAGO LIMITED

DENTAL CLAIM FORM

MEMBER'S STATEMENT: ***(Please complete and submit to the Benefit Plans Department)***
Please Print Information

1. **Employee:** ☐ **Hourly/Weekly** ☐ **Monthly Paid** ☐ **Retiree** *(Please tick appropriate box)*

2. **Member's Name:** _____ **Emp. # / Ret. I.D** _____

3. **Patient's Name:** _____

4. **Relationship of patient to Employee/ Retiree:** **Self** ☐ **Spouse** ☐ **Child** ☐

5. **Retiree's Address:** _____

6. **Is patient covered through any other plan, which provides dental benefits or service?** YES ☐ NO ☐
   If yes please state the name of the Employer of Insurance company that provides this coverage:

NAME	ADDRESS

7. **Was the expenditure incurred due to an emergency?** YES ☐ NO ☐
   If yes, please give details:
   _____

8. **Are the statements/bills and receipt for ALL expenses attached in support of your claim?** YES ☐ NO ☐

I acknowledge that reimbursement would be made up to the limits of the plan and certify that the foregoing answers are true and correct to the best of my knowledge and authorise all doctors, and other persons who treated me to furnish full information, when necessary (including full copies of their records) regarding this claim, to the Senior Medical Officer, Petroleum Company of Trinidad and Tobago Limited.

Date: _____ **Signature of Member** _____ **Tel.:** _____

FOR OFFICIAL USE BENEFIT PLANS DEPARTMENT

Reimbursement is payable to _____ Member's I.D. # _____

PENSION FUND: ☐ **EBP** ☐ **EPP** ☐ **SRP** ☐ **SPP** ☐ **FUND B** ☐ **FUND A** ☐ **NCPF**

For pre-paid Dental costs as per the terms and agreements of the Medical Plan. *(See other side for details of charges)*

ORTHODONTIA TREATMENT YES ☐ NO ☐ TREATMENT #: _____

TOTAL reimbursement amount to **$**_____

Prepared by: _____ Verified by: _____

Approved by: _____ Date: _____
Admin., Pensions & Employee Benefits

PETROLEUM COMPANY OF TRINIDAD AND TOBAGO LIMITED

ATTENDING DENTIST'S STATEMENT

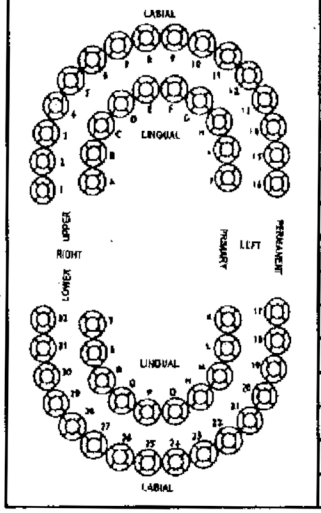
Dentist's Name: _____ **Address:** _____

_____

Name of patient: _____ **Member's ID #** _____

Accident Injury : **YES** ☐ **NO** ☐

EXAMINATION AND TREATMENT RECORD



Date of Visit	Tooth # or Letter	No. Of Surfaces	Category of procedure eg. Diagnostic, Periodontics	Description of Services performed & Materials used Including X-Rays, Prophylaxis, Extractions etc	Fees	Company Use only
				Total		
				Amt. Paid		
				Balance		

Are any further treatments necessary? **YES** ☐ **NO** ☐

DENTIST'S STAMP

If yes please give details: _____

_____

_____

I hereby certify that the services listed above have been performed.

DENTIST'S SIGNATURE: _____ **DATE:** _____