TRINMAR OPERATIONS
POINT FORTIN
DENTAL CLAIM FORM

MEMBERS' STATEMENT: *(To be completed, signed and submitted to the Medical Department)*
(Please PRINT information)

1. **Member's Name:** _____ **Emp./Staff /Ret. No.:** _____
2. **Patient's Name:** _____ **Emp.** ☐ **Staff** ☐ **Ret.** ☐ **Dep.** ☐
3. **Relationship of patient to Employee:** **Self** ☐ **Spouse** ☐ **Child** ☐
4. **Is patient covered through any other plan, which provides dental benefits or service?** YES ☐ NO ☐

   If YES, please list the name of the Employer or Insurance Company that provides this coverage:

NAME	ADDRESS

5. **Name of attending Physician: Dr.** _____
6. **Was the expenditure incurred due to an emergency?** YES ☐ NO ☐

   If YES, please give details:

   _____

   _____

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

I acknowledge that reimbursements would be made up to the limits of the plan and certify that the foregoing answers are correct and true to the best of my knowledge and authorise all doctors, other persons who treated me and all hospitals/institutions to furnish full information, when necessary (including full copies of their records) regarding this claim, to the Senior Medical Official, Petrotrin, Trinmar operations.

Date: _____ **Signature of Member:** _____

BENEFITS SECTION ONLY
ASSIGNMENT OF BENEFITS

Reimbursement is payable to _____ Medical I.D # _____

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 TTD$_____

Prepared by: _____ Date: _____

Approved by: _____ **Date:** _____

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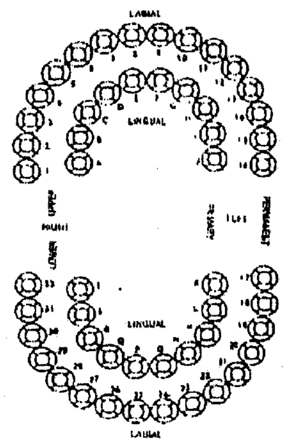
ATTENDING DENTIST'S STATEMENT

Dentist's Name: ______________________________ Address: ______________________________
(Please PRINT)

Patient's Name: ______________________________ Medical I.D./Ref. No.: ______________

Accidental Injury: YES ☐ NO ☐

EXAMINATION AND TREATMENT RECORD



Date of Visit	Tooth # or Letter	No. of Surfaces	Category of Procedure [Diagnostic, Peridontics]	Description of Services Performed and Materials Used[including X-rays; Prophylaxis extraction etc]	Fees	Company Use ONLY
				Total		
				Amt. Paid		
				Balance		

Any further treatments necessary? YES ☐ NO ☐

If YES, please give details: ______________________________

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

DOCTOR'S SIGNATURE: ______________________ DATE: ______________