BAF FINANCIAL INSURANCE (BAHAMAS) LIMITED

GROUP INSURANCE DENTAL CLAIM FORM

To be completed by the Treating Physician
(PLEASE USE BLOCK LETTERS)

BAF TIN #: 100239418

PATIENT SECTION

Name of Patient: FIRST _____ MIDDLE _____ LAST _____

2. Relationship to insured: Self Spouse Child Other 3. Sex: Male Female

4. Patient birth date: (MM/DD/YYYY) _____ 5. If full time student: School name: _____ City/Country _____

6. Insured's Name: _____ 7. Insured's Date of Birth _____ 8. Address _____

9. Is patient covered by another plan of benefits? Yes No Dental Medical

10. If Yes, name and address of carrier(s): _____ Policy number(s) _____

11. Name and address of employer _____

I have reviewed the following treatment plan and hereby authorize release of any information to this claim. I understand that I am responsible for all costs of dental treatment.
Signature of Insured/Patient: _____ Date: _____

PROVIDER / DENTIST SECTION

1. Dentist Name: _____ 2. Dentist Number _____

3. Address: _____ 4. Telephone Number _____ 5. First date of current treatment _____

6. Radiographs or models enclosed? **Yes No** 7. Is treatment a result of occupational illness or injury? **Yes No** If yes – Describe on back of form

8. Is treatment a result of an auto accident? **Yes No** / Other form of accident? **Yes No** If yes describe on back of form

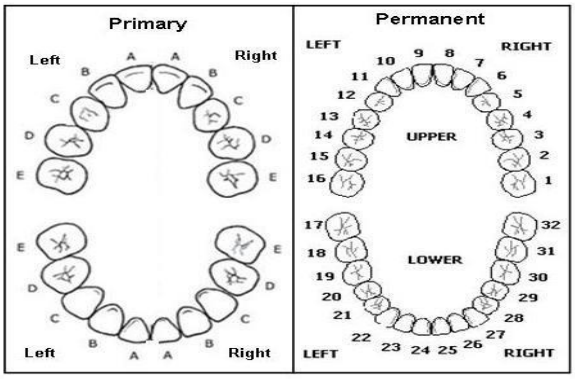
9. Are any services covered by another plan? **Yes No** If yes please provide details on back of form

10. If prosthesis, is this initial replacement? **Yes No** If no state reason for replacement _____

Date of prior replacement _____ 11. Is treatment for orthodontics? **Yes No**

If service already commenced, state date appliance was placed _____ Date of prior placement _____ Months of remaining treatment _____

IDENTIFY MISSING TEETH WITH AN "X"



EXAMINATION AND TREATMENT PLAN-LIST IN ORDER OF TOOTH NO. 1 – 32

Tooth No	Surface	Description of Service	Date of Service	Procedure No.	Fee

Remarks for Unusual Service:

I herby certify that the procedures as indicated have been completed

Signature of provider _____ Date _____

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