Dental Insurance
Claim Form

Internacional de Seguros

Company with whom you have the Policy: _____

Policyholder's Name: _____

Email: _____ **Phone:** _____

Name of person receiving the service: _____ **Identification N°:** _____ **Age:** _____

Name of Treating Dentist: _____ **Phone:** _____

SECTION I: To be completed by the Policyholder or Claimant

Type of condition: Accident ☐ Illness ☐ Other: _____

In case of Accident:

Describe the event: _____

Date of Occurrence: _____

I hereby certify that the foregoing answers and the attached invoices are true and accurate to the best of my knowledge and belief. I authorize all physicians and other persons who treated me and all hospitals and other institutions to provide Aseguradora del Istmo (ADISA) S.A. with any information including exact copies of their records, laboratory examinations and X-rays pertaining to this claim. It is understood that the Company reserves the right to defer settlement of this claim until all evidence necessary for settlement has been obtained to its complete satisfaction.

Date: _____ Policyholder's signature: _____

Remember to attach invoices for all dental services received, as well as orders for study requests with their respective reports or results (images, others) prescribed by your Treating Dentist.

SECTION II: To be completed by the Treating Dentist or Supplier

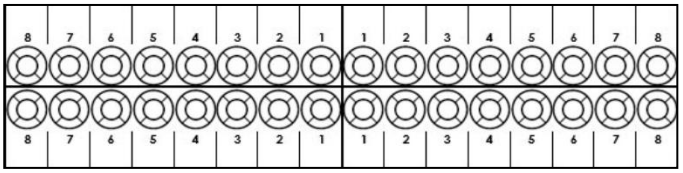
Patient's Name: _____ **Age:** _____

Type of condition: Accident ☐ Illness ☐ Other: _____ **Date of onset of condition/ illness/accident:** _____

Diagnosis/Diagnostic Impression/Symptoms (Detail):

*In case of Accident, describe the mechanism

Mark the pieces treated:



Tooth N°.	Surface	Description Service	Amount

Note: As the treating Dentist, I authorize hospitals and other institutions to provide the Insurance Company covered by this policy with all reports concerning the health of the insured patient, including all data on past illnesses. To this effect, in this case, I release the institutions or persons involved from professional secrecy and I state for the record that a copy of this authorization has the original value. Under oath, I declare that the information provided in this form was taken directly from both the insured patient and the clinical record.

Physician's Signature and Medical Code: _____ Stamp: _____ Date: _____

THE INSURANCE COMPANY will reimburse the medical fees charged, based on the individual conditions of the contracted policy. In no case will expenses that are not reasonably necessary be recognized as covered expenses, nor will any be paid more than the amount that should USUALLY be recognized for the service or drug in question.

The contractual documentation and the technical note that compose this product are registered before the General Insurance Superintendence in accordance with the provisions of Article 29, paragraph d) of the Insurance Market Regulatory Law No. 8653, under registration No. P20-64-A07-399, dated January 17, 2013.