Generali Worldwide
Health Insurance – Dental Claim Form

Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

INSTRUCTIONS FOR FILING A DENTAL CLAIM

1. Please type or print and include all requested information
2. A separate claim form must be completed for each family member who is making a claim
3. Attach all original fully itemized dental bill(s) to the completed form
4. SECTIONS A, B, C, D, E and F – must be completed by the Insured (Employee)

   NOTE: This section must be completed in its entirety in order to process the claim
5. SECTIONS G, H and I – must be completed by the Provider of Services

   NOTE: If you have a fully itemized dental bill, the Provider of Services does not need to complete Sections G and H of the Dental Claim Form, but all documentation, fully itemized medical bill(s) and receipt(s) must include:

   - Patient Name
   - Date of Service
   - Diagnosis/ Nature of Illness, and Procedures performed
   - Billed Charges
   - Currency for each Service Provided

If all of the above information is not indicated on the bill(s)/ receipt(s), then the Provider of Services must complete Sections G and H.

All documentation and related correspondence must be sent to:

Generali Worldwide
P.O. Box 306
266 Elmwood Avenue, Buffalo NY 14222
Tel: +1 905 762 5193 Fax: +1 905 762 5194

generali-healthcare.com

ONLINE ACCESS

To view your information online, please login to https://services.hi-techhealth.com/bah/pages/signon.shtml and enter in your username and password.

If you are logging in for the first time, please follow the instructions below:

- Your default Username is your Member ID number or your National Insurance Board number
- Your default Password is your date of birth in an eight digit format (MM/DD/YYYY)
- After this initial login, you will be prompted to immediately change your password

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Once you have successfully logged onto the Member portal, select the [Start Here] button located in the top left corner. You will have instant access to the following information:

1. **Employee Claims** – you will be able to view the status of your claims, see payment details, as well as print Explanation of Benefit(s).

2. **Employee File View** – you will be able to view your coverage information, as well the dependents that are part of this policy. This section will also allow you to verify the accuracy of the information.

3. **Online Documents** – you have the ability to download a copy of your policy, print claim forms and have access to any other available references.

Online access is available to you 24/7, 365 days a year.

If you have any questions regarding your access, or require additional information, please contact us at +1 242 328 0935.

SECTIONS A, B, C, D, E, AND F ARE TO BE COMPLETED BY INSURED (EMPLOYEE).

A. INSURANCE INFORMATION

Group Name:

Group Number: Policy ID number:

B. EMPLOYEE INFORMATION

Employee's Name (Last, First, MI):

Date of Birth: M M D D Y Y NIB No:

Address: (No., Street, Island, Country):

Telephone No (including area code):

C. PATIENT INFORMATION

Patient Details (if different than Section B)

Patient's Name (Last, First, MI):

Date of Birth: M M D D Y Y

Address: (No., Street, Island, Country):

☐ Same as Section B

Telephone No (including area code):

Patient Sex: Male ☐ Female ☐ Patient's Relationship to Insured: Spouse ☐ Child ☐ Other ☐

Is the Dependant a full-time student? Yes ☐ No ☐

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D. COORDINATION OF BENEFITS

Is the patient covered by another health plan? Yes ☐ No ☐

If YES, please provide Insurance Company Name and Address

Name of Insured:

Group Name:

Group Number: Policy ID number:

Effective Date of Coverage: M M D D Y Y Is the Patient the: Insured ☐ Dependant ☐

Is this claim work related? Yes ☐ No ☐ Is this claim related to an accident? Yes ☐ No ☐

Date of Incident: M M D D Y Y

Please provide a brief description of how the injury or accident occurred.

An incident/ accident report describing the nature and cause of the injury must accompany the claim form. In addition, if the accident is a result of a Motor Vehicle Accident, you must also include a Police Report. Failing to do so could delay the processing of your claim.

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E. ASSIGNMENT OF BENEFITS

ASSIGNMENT: Please pay the balance due directly to the Provider at the address indicated in Section I Yes ☐ No ☐

If NO, please indicate your preferred method of payment. Select only one option.

1. ☐ Cheque - Indicate preferred currency

☐ Based on Policy Currency (Bahamian or U.S. Dollars)

☐ Issue in U.S. dollars; please ensure your bank will accept U.S. currency
NOTE: The cost of a U.S. bank draft is the responsibility of the Insured and will be deducted from the payable amount

2. ☐ Wire Transfer - You must fill out the International Wire Transfer Request form.
This can be found on the Member Portal at https://services.hi-techhealth.com/bah/pages/signon.shtml in the Online Document Section.

NOTE: The cost of the wire transfer is the responsibility of the Insured and will be deducted from the payable amount

ASSIGNMENT OF BENEFITS TO PROVIDER OF SERVICES I hereby authorize payment directly to the undersigned Provider of Services, if any, otherwise payable to me for services rendered as described below but not to exceed the reasonable customary charge for those services.

Signature of Insured Person (Parent or Guardian if claim is for a minor):

Date: M M D D Y Y

F. AUTHORIZATION TO RELEASE INFORMATION - CLAIM CANNOT BE PROCESSED WITHOUT THE INSURED'S SIGNATURE

AUTHORIZATION I certify that the information furnished by me in support of this claim is true and correct. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, pharmacist, educational institution or other person to release any information requested with respect to this claim. A photostatic copy or other reproduction of this release will be as valid as the original.

Signature of Insured Person (Parent or Guardian if claim is for a minor):

Date: M M D D Y Y

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SECTIONS G, H AND I ARE TO BE COMPLETED BY PROVIDER OF SERVICES.

G. IF TREATMENT IS A RESULT OF AN ACCIDENT, PLEASE FILL IN THIS SECTION

Please indicate date(s) and a brief description

Date of First Visit: M M D D Y Y

Date of Tooth Loss: M M D D Y Y

X-Rays or Models Enclosed? Yes ☐ No ☐

How many?

If Prosthesis, is this the initial placement? Yes ☐ No ☐

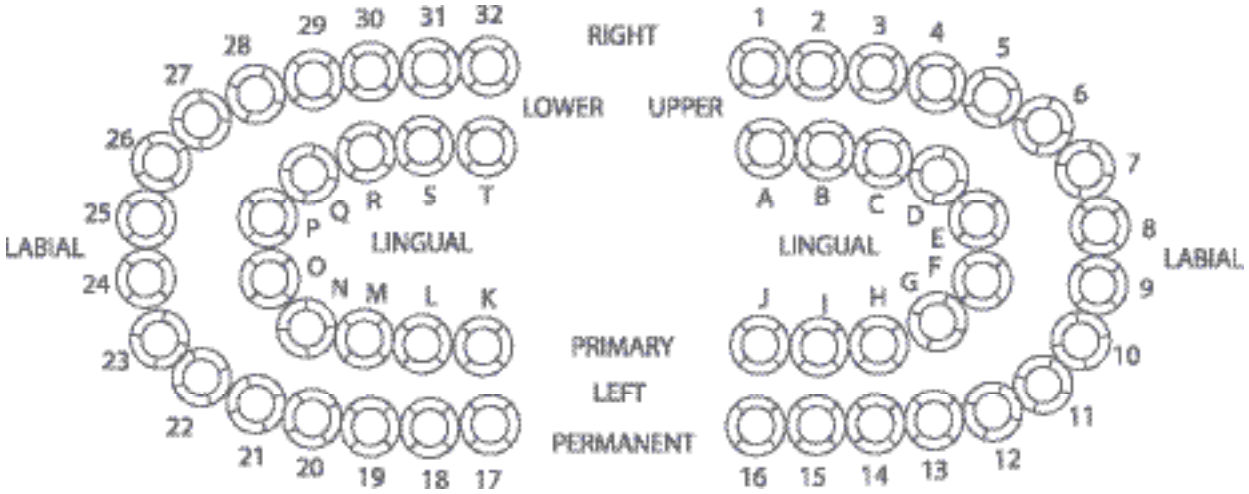
If YES, please provide date of extraction of teeth being replaced: M M D D Y Y

If NO, please give reason for replacement and date of prior placement:

Date: M M D D Y Y

H. SUMMARY OF SERVICES PROVIDED

Please have Dentist complete this section. Indicate missing teeth with an "X"



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Date of Service (MM/DD/YYYY)	Tooth Number or Letter	Surface	Service Code	Description of Service (including X-Rays, prophylaxis, material used, Root Canals (# of Canals), etc)	Diagnosis Code	Unit	Charges
					Total Charges		
					Amount paid		
					Balance Due		

Patient Account Number: Accept Assignment: Yes ☐ No ☐

Physician/ Provider ID Number:

I. PROVIDER INFORMATION AND AUTHORIZATION

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

Name of Provider:

Address of Provider (No., Street):

City, Island, Country:

Telephone (include area code):

Fax (include area code):

Provide official stamp (if available)

Signature:

Date: M M D D Y Y

J. DISCLAIMER

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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