ARGUS
Our Interest is You.

Dental Claims Form

Bermuda Life Insurance Company Limited

☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

A. Patient Section

Patient Name	Surname	Middle Initial	Date of Birth	Gender	Relationship to employee
				☐ Female ☐ Male	☐ Self ☐ Spouse ☐ Child ☐ Other

Employee Name	Surname	Employer (Company) Name	If Patient is a full time student – Name Of School

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.	Group Policy Number	Employee Certificate Number

Signed (Patient or parent if minor) Date (MM/DD/YY)

B. Dentist Section

Dentist Name	Mailing Address	Email Address

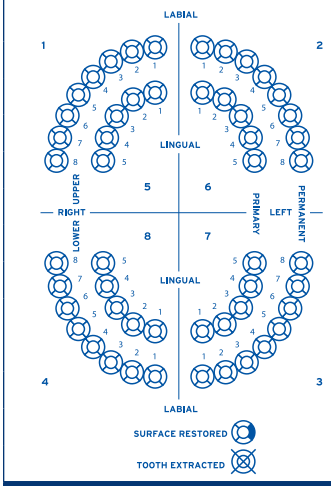
Dentist's phone number	NPI #	Is treatment result of occupational illness or injury?
		☐ Yes ☐ No If yes, enter brief description and dates

First Visit Date Current Series	Is treatment a result of auto accident or other accident?
	☐ Yes ☐ No If yes, enter brief description and dates

Place of Treatment	If denture, crown or bridge, is this the initial placement?
☐ Office ☐ Hospital ☐ Other	

Radiographs or models enclosed	If no, give date of prior placement and reason for replacement
☐ No ☐ Yes How many	

Is treatment for Orthodontics?	If services already commenced enter date appliances placed (MM/DD/YY)	Mos, treatment remaining
☐ Yes ☐ No		



Date Service Performed	Tooth No	Surface	Description of Service (including X-Rays, prophylaxis, materials used, etc.)	Procedure Code	Fee	Admin use only

For Argus Use Only

For additional information re: diagnosis, procedures, or complications and time in units.	Total Fee Charged	
	Max Allowable	
	Deductible	
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.	Insurer %	
	Insurer Pays	
	Patient Pays	

Signed (Dentist) Date (MM/DD/YY)

ELIGIBILITY FOR BENEFITS IS DETERMINED BY THE TERMS AND CONDITIONS OF YOUR POLICY.
PRE-TREATMENT ESTIMATE FOR MAJOR RESTORATIVE WORK IS RECOMMENDED.