



# DENTAL EXPENSE CLAIM FORM

Claim Form, original itemized bills and all related correspondence must be mailed to:

**Sagikor Allnation Insurance Company**  
c/o Sagikor International Management Svcs.  
4010 W. Boy Scout Blvd., Suite 800  
Tampa, Florida 33607-5735 USA

**Toll Free:** (800) 342-0719  
**Telephone:** (813) 286-2222  
**Fax:** (813) 287-7420

Insurance products provided by  
**Sagikor Allnation Insurance Company**  
<http://www.allnation.com>

## IMPORTANT: PLEASE READ INSTRUCTIONS CAREFULLY

Complete all relevant sections of this Claim Form. A separate Claim Form must be completed for each individual making a claim, however, multiple dental claims can be submitted on a single form. Original documentation (itemized bills and receipts) must be submitted with the Form. Photocopies of documents are NOT acceptable.

**SECTIONS A, B & C TO BE COMPLETED BY INSURED – Please Print**

<b>A. GENERAL INFORMATION</b>	
Name of Insured Person (Last, First, MI):	Alias:
Birth Date: (MM/DD/YR)	Allnation Policy Number:
Name of Patient (Surname, First Name, Middle Initial):	
Birth Date: (MM/DD/YR)	Relationship to Insured:
Home Country:	Country of Assignment:
Mailing Address (Home Country):	Mailing Address (Country of Assignment):
E-mail Address:	
Telephone Number (Home Country):	Telephone Number (Country of Assignment):
Is There Another Dental Benefit Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>B. ASSIGNMENT OF BENEFITS</b>	
1. Assignment: Please pay provider directly to the address indicated on the attached original provider invoice. <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Insured's Signature	3. Date Signed
<b>C. AUTHORIZATION TO RELEASE INFORMATION</b>	
I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.	
4. Insured's Signature	5. Date Signed
<b>CLAIMS REIMBURSEMENT INFORMATION</b> - Claims are reimbursed in U.S. Dollars by check.	
<b>D. FRAUD WARNING</b>	
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.	

