

Dental Cost Estimate

For completion by your dental practitioner.
Please note, this document is not for use as an invoice or Claim Form.

Details of recipient of treatment

Eurotrainee institution

Personal policy number (N/A when claiming for the 1st time)

EU Institution group policy number (This number is indicated on your Insurance Certificate)

Mr. Mrs. Ms. Miss Other

First name

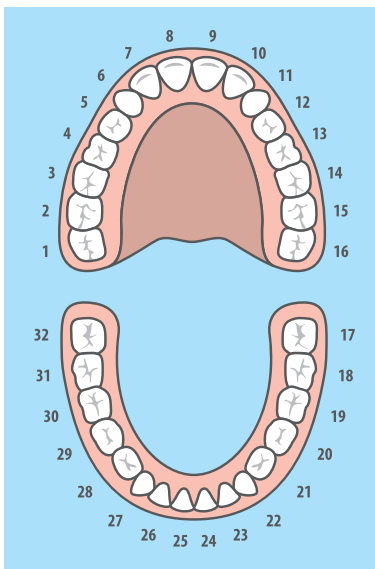
Surname

Full address

Date of birth / /

Dentition diagram

Blacken out missing teeth and indicate with arrows the teeth to be attended to for this estimate.



Dental treatment	Tooth number	Estimated fees
Filling		
Extraction		
Root canal treatment		
Fixed prosthesis		
Gold crown, resin jacket		
Resin bridge tooth element		
Gold inlay, cast dummy		
Pivot crown		
Veneer or Richmond crown or metal ceramic crown		
Metal ceramic bridge device		
Gold and porcelain bridge tooth element		
Spring attachment		
Hinge		
Removable prosthesis		
Upper jaw		
Number of teeth to be replaced		
Clasp		
Attachment		
Suction system		
Base: resin <input type="checkbox"/> chrome-cobalt <input type="checkbox"/> gold <input type="checkbox"/>		
Repair to the resin base		
Addition of tooth or clasp on resin base		
Rebasing		
Remounting		
Lower jaw		
Number of teeth to be replaced		
Clasp		
Attachment		
Suction system		
Base: resin <input type="checkbox"/> chrome-cobalt <input type="checkbox"/> gold <input type="checkbox"/>		
Repair to the resin base		
Addition of tooth or clasp on resin base		
Rebasing		
Remounting		

Dental treatment	Tooth number	Estimated fees
Temporary dentures		
Crown		
Tooth to be replaced (bridge pontic or tooth on removable denture)		
Clasp		

Periodontic treatment (indicate site on diagram)	Details incl. quadrant	Tooth number	Estimated fees
Non-surgical treatment			
Surgical treatment			
Other			
Implants	No. of implants		
Sub-periosteal implant			
Endo-osseous implant			
Special treatment	Details		
Occlusal cap-splint			
Other			
Total estimated fees			


Dental practitioner details

Dentist's name

Practice name and address




Telephone number COUNTRY CODE AREA CODE

Practitioner's stamp

 Practitioner's signature _____

Date / /

Please complete, sign and return this form by:

-  Email to: igomedical@e.allianz.com
-  Fax to: + 32 2 210 6597
-  Post to: Allianz Care, Bd Roi Albert II 32, 1000 Brussels, Belgium

The Underwriter of your insurance is AWP Health & Life SA, a limited company with a capital of €72,104,026 governed by the French Insurance Code, with its registered office at 7 Rue Dora Maar, 93400 Saint-Ouen, France. Registered in France: 401 154 679 RCS Bobigny. VAT number: FR 84 401 154 679. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

The Administrator of your insurance is AWP Health & Life Services Limited – Belgium Branch having its branch trading address at Bd Roi Albert II 32, 1000 Brussels, Belgium. VAT: BE 0843.991.159. RPM Bruxelles: 843.991.159. Allianz Care and Allianz Partners are registered business names of AWP Health & Life Services Limited.