

REFUND FORM FOR DENTAL EXPENSES
(In the case of a family unit, use one form for each person)

This form must be sent to:
FONDO SANITARIO INTEGRATIVO DEL GRUPPO INTESA SANPAOLO
Ufficio Liquidazioni c/o Previmedical S.p.A.
Via E. Forlanini 24 – 31022 Preganziol (TV)
Together with a photocopy of medical and expenses documentation*

The undersigned asks for a REFUND

Working Members/Affiliated working members

Retired Members/Affiliated retired members

PERSONAL DATA OF THE POLICY HOLDER

Surname _____ Name _____
Born in _____ on _____ Gender M F Tax Code _____
Phone _____ Cell _____ (fill in if you intend to use the service "FOLLOW YOUR CLAIM")
E-mail _____ @ _____
ID Number _____ Company Name _____

PERSONAL DATA OF THE FAMILY MEMBER FOR WHICH A REFUND IS REQUESTED

Surname _____ Name _____
Born in _____ on _____ Gender M F Tax Code _____

Space reserved to long absentee members, early retired or retired members for documentation return

Address _____ n. _____ City _____ (____)

Services for which a refund is requested:

The dentist will have to subscribe the service(s) for which the refund is requested by filling in the details on the form enclosed herewith.

Herein find attached **COPY** of the following invoices:

| | Invoice/ Receipt number | Issued by | Invoice/ Receipt date | Amount | | | | | | | | | | | | | | | | |
|---|-------------------------------|-----------|--------------------------|--------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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| 1 | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | | | | | |

Total amount requested net of stamp duty (if present on the expense document):

_____ . _____

* The Plan reserves the right to ask for original documentation in the 5 (five) years following the invoices financial year, in order to carry out statutory verifications.

OTHER INSURANCE COVERAGE / ACCIDENT COVERAGE WITH THIRD-PARTY LIABILITY

(The failure to complete this section will entail the rejection of the request.)

Reference to the Treatment Regulations – General Rules – Paragraph V:

“In the presence of charges reimbursable by the National Healthcare Service, the reimbursement and/or permanent advance by third parties - including following accidents caused by the same - or in the presence of other, similar coverage for oneself and/or for family-member beneficiaries, the undersigned has the obligation to provide formal notice thereof to the “Fondo Sanitario” (Healthcare Plan) that will pay for the treatments, net of the amount reimbursed and/or advanced. Should the participant instead intend to request, in first instance, the reimbursement from the “Fondo Sanitario”, the reimbursement will occur on a definitive basis and without application of a deferred portion, in an amount equal to 50% of the amount due in application of these Treatment Regulations”

The undersigned declares that the expenses sustained: *(check box applicable)*

- are not covered by another other form of insurance or referable to an accident with third-party liability;
- are covered by another form of insurance or are referable to an accident with third-party liability and accordingly requests, in first instance, of the n, the final payment of 50% of the sum due;
The expenditure sustained, net of any deductible, will be settled in the amount of 50% on a definitive basis and without application of any deferred portion.
- are covered by another form of insurance or are referable to an accident with third-party liability and accordingly, requests in second instance, of the Plan, the settlement of the expenditure remaining for the undersigned's account.
The expenditure remaining for the account of the undersigned will be settled for 100%, should the same be less than or equal to the maximum limits reimbursable according to the criteria in effect and with application of the deferred portion, if provided. Attach the settlement letter of the other insurance, indicating the detail of the expenditures reimbursed. In this case, the deadline for the presentation of the request is extended, with respect to the ordinary deadline, to 90 days from the date of the reimbursement obtained from third parties.

Signature of Policyholder _____

In the event of **HOSPITALISATION**, complete the following section:

Hospital stay: from _____ to _____ **With surgery** **Without surgery** **Daily allowance**

Invoices referring to **Pre-hospitalisation** **Hospitalisation** **Post-hospitalisation**

N.B.: In the event of **HOSPITALISATION IN A PRIVATE FACILITY**, the medical records must be attached.

No. documents attached to this application (invoices, medical records, certificates of hospital stay, etc.): _____

Date of completion: _____ **Signature of Policyholder:** _____

Signature of beneficiary of the treatment _____
(if a minor, signature of the parent or guardian)

Consent to the processing of personal data – Italian Legislative Decree no. 196/2003

The undersigned, in relation to the disclosure statement already received pursuant to Article 13 of LD no. 196/2003, consents to: the processing of his/her personal data, including sensitive data, acquired or to be acquired as part of the Healthcare Plan's statutory purposes; the communication of such data to the persons indicated in the disclosure statement; and the Plan's communicating and making visible the data to the member which made the undersigned a beneficiary.

Date of completion: _____

Name and surname _____

Signature for Consent of Beneficiary of Treatment _____

(if a minor, signature of the parent or guardian)

| QTY | SERVICE | QTY | SERVICE |
|----------------------|---|--------------------------|---|
| PREVENTION | | SURGERY | |
| | Periodic oral evaluation | | Simple tooth or root extraction |
| | Emergency visits (with emergency surgery) | | Complex tooth or root extraction (or in partial bone inclusion) |
| | Occlusal or intra-oral x-ray or bite – wing | | Tooth or root extraction in complete bone inclusion |
| | X-ray: for each further radiogram | PROSTHESIS | |
| | Prophylactic/simple tartar ablation - Adult | | Prosthesis crown in LNP or ceramic |
| | Prophylactic/simple tartar ablation – Child | | Prosthesis crown in LP and ceramic |
| | Fluorine topical application (Prophylactic excluded) - Child | | Prosthesis crown in full ceramic |
| | Fluorine topical application (Prophylactic excluded) – Adult | | Temporary simple resin prosthesis crown |
| VISITS | | | Pivot (fused/premade/carbon fiber) |
| | Oral check, specialist visit | | Upper resin full prosthesis |
| | Oral hygiene | | Lower resin full prosthesis |
| RADIOLOGY | | | Upper partial resin prosthesis (up to 3 elem. Including clamps) |
| | Front – rear or lateral cranium and facial bones x-ray | | Lower partial resin prosthesis (up to 3 elem. Including clamps) |
| | Dental orthopantomography (OPT) | | Removable prosthesis in stellitic alloy up to 3 elem. – upper arch. |
| CONSERVATION | | | Removable prosthesis in stellitic alloy up to 3 elem. – lower arch. |
| | Sealing (for each tooth) | | Removable prosthesis clamp |
| | Compound or amalgam filling (1-2 surfaces) | | Prosthesis repair |
| | Compound or amalgam filling (3-5 surfaces) | | Add. Element on partial prosthesis or on removable prosthesis |
| PARADONTOLOGY | | | Prosthesis definitive lowering, upper total prosthesis indirect technique |
| | Roots scalling and honing (up to 6 teeth) | | Prosthesis definitive lowering, lower total prosthesis indirect technique |
| | Extra coronal dental wiring (4 teeth) | | Prosthesis definitive lowering, upper total prosthesis direct technique |
| | Gingivectomy (for 4 teeth) | | Prosthesis definitive lowering, lower total prosthesis direct technique |
| | Gingivectomy per tooth | | Precision joint in LNP |
| | Simple gingival flap for 4 teeth | ORTHOGNATODONTICS | |
| | Mucus flap/ging. repos. apic./couret. open (4 teeth) | | Case study |
| | Rizectomy per root (including access flap) | | Ort. Therapy fixed braces per arch/year (teenagers) |
| ENDODONTICS | | | Ort. Therapy fixed braces per arch/year (adults) |
| | Crown pulp amputation and pulp cavum filling (deciduous) | | Ort. Therapy removable braces per arch/year |
| | Intra oral therapy 1 root canal (including diagnostic x-ray) | | Orthodontic visit with modelling |
| | Intra oral therapy 2 root canal (including diagnostic x-ray) | | Night bite |
| | Intra oral therapy 3 root canal (including diagnostic x-ray) | IMPLANTOLOGY | |
| | | | Bony stable implant (including premade pillar) |
| OTHER: | | | |

OPTION IS RESERVED SOLELY TO SERVICE MANAGEMENT SUBSCRIBERS

I hereby request the possibility to dispose of the coverage cap of € 4.500 merging the ceiling for the current year (net of eventual already received reimbursements) and for the two following years. The services provided refer to a care plan for which I enclose a single invoice of an amount equal or superior to € 6.500.

Teeth numbers layout

| RIGHT UPPER ARCH I QUADRANT | | | | | | | | LEFT UPPER ARCH II QUADRANT | | | | | | | |
|------------------------------|----|----|----|----|----|----|----|------------------------------|----|----|----|----|----|----|----|
| 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
| RIGHT LOWER ARCH IV QUADRANT | | | | | | | | LEFT LOWER ARCH III QUADRANT | | | | | | | |

Services list

| Service | Quantity | Tooth/Teeth | Arch | Notes |
|---------|----------|-------------|------|-------|
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Date of completion _____

Dentist signature and stamp _____