Insurance Information Form

Urban Dental Clinic | KN 2 St, TCB Building, Kigali | +250 788 200 723

Policy holder

Full name: _____

Relationship to patient: _____

Phone: _____

Insurer

Insurance provider: _____

Policy / member number: _____

Scheme or plan: _____

Co-payment percentage (if known): _____

Authorisation

I authorise Urban Dental Clinic to share the treatment details required to process my claim.

Signature: _____ Date: ____ / ____ / _____

Sample form — final version will be provided by the clinic.