dpas your dental plans

Supplementary Insurance claim form

DENTAL EMERGENCY – CALL OUT FEE OR TELEPHONE CONSULTATION

Reference to the Supplementary Insurance policy document will assist you when completing this form. Please note any exclusions in the policy which may apply. You are responsible for the first £15.00 of the call out fee.

To make a claim under the Supplementary Insurance this form should be **fully** completed by you, the patient, to avoid any delay in your claim being processed. The claim form must reach DPAS Limited within 30 days of the emergency incident.

The treating dentist must sign the declaration on page two. If you have paid the dentist's account please enclose the original receipt. In this instance the dentist's signature is not required.

Claim forms for Dental Injury and Emergency treatment away from home are available from the DPAS Insurance Team. You can also download the form from our web site www.dpas.co.uk. If you have any queries please call the DPAS Insurance Team on 01747 873230.

YOUR DETAILS

Title: _____ Forename(s): _____ Surname: _____ DOB: _____

Address: _____

_____ Postcode: _____

Home phone: _____ Daytime phone: _____ Dental Plan Registration No: _____

If you would like correspondence regarding your claim sent by email please provide your email address:

E-mail: _____

YOUR REGISTERED DENTIST DETAILS

Title: _____ Forename(s): _____ Surname: _____

Practice Name: _____ DPAS Practice reference number: _____

Address: _____

_____ Postcode: _____

YOUR TREATING DENTIST DETAILS (If different from above)

Title: _____ Forename(s): _____ Surname: _____

Practice Name: _____ Practice reference number: _____

Address: _____

_____ Postcode: _____

Practice phone: _____ E-mail: _____

Have you made any previous claims under any dental insurance policy? ❍ Yes ❍ No

If yes, please give details and dates: _____

_____

_____

CLAIM FOR EMERGENCY CALL OUT FEE OR TELEPHONE CONSULTATION

Treatment Date: _____ Time of treatment: _____

Did the dentist have to open his or her surgery to treat you? ❍ Yes ❍ No

Have you incurred a call out fee? ❍ Yes ❍ No Amount: £ _____

Are you claiming for a telephone consultation? ❍ Yes ❍ No Amount: £ _____

Please provide details of the emergency and the treatment received: _____

_____

PAYMENT INFORMATION

Payment should be made to:

- ❍ **Patient:** Payment will be made directly to the account from which your dental plan payments are requested
- ❍ **Your DPAS registered dentist:** Payment will be made directly to the bank account held on our records
- ❍ **Treating dentist**

Payments will be made direct to your bank account, unless otherwise requested:

Account Name: _____ Please pay by cheque payable to:

Account Number: _____ _____

Sort Code: _____

DENTIST DECLARATION

Are you the patients registered dentist? ❍ Yes ❍ No

If no, are you on the emergency rota? ❍ Yes ❍ No

Dentist's signature: _____

Name (please print): _____ **Date:** _____

Please enclose original receipts if you have paid the dentist's account. In this instance a dentist's signature is not required.

PATIENT'S DECLARATION – ALL PATIENTS MUST SIGN

If patient is under 18 years then the declaration must be completed by the parent/guardian.

I warrant the truth of the information given enclosed. I understand that the issue of this form is not an admission of my claim. I am also aware that DPAS Limited may wish to make enquiries, in which respect I consent to any dental or medical practitioner or other person in possession of information relevant to my claim to disclose that information to DPAS without reference to me. I consent to DPAS contacting me. I acknowledge that DPAS may invite me to undergo examination by a dentist or doctor, and that if I decline it may refuse my claim.

The information that you and your dentist have provided in the claim form is sensitive data as defined by the Data Protection Act 1998. Sensitive data includes any information about your dental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future. In order to administer your claim, this information will be used by ACE European Group Limited and its group companies and DPAS. It may be held on computer and or in manual files for administration, and risk assessment purposes. Both companies may disclose your personal data and sensitive data to, and may request information from other companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries, which do not provide the same level of data protection as the UK, if necessary, for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

When you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their administration abroad and to receive on their behalf any data protection notices.

Patient's signature: _____ ❍ Parent ❍ Guardian

Name (please print): _____ **Date:** _____

The completed form should be returned within 30 days of the incident date from which the claim arose to:

DPAS LIMITED, PLACE FARM COURTYARD, COURT STREET, TISBURY, WILTSHIRE SP3 6LW

Insurance team direct line: 01747 873230 **Insurance team e-mail:** insurance@dpas.co.uk

General enquiries relating to your plan: 01747 870910

Registered Address: DPAS Limited, Place Farm Courtyard, Court Street, Tisbury, Wiltshire SP3 6LW Registered in England No: 3247652
Registered Branch Address: DPAS Ireland, 51-52 Fitzwilliam Square West, Dublin 2 Registered Branch No: 906349
Directors: Quentin Skinner, Andrew Warren and Stephen Noar
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