dpas your dental plans

INSURANCE

Supplementary insurance claim form

Dental injury and emergency

Reference to the Supplementary Insurance policy document will assist you when completing this form. Please note any exclusions in the policy which may apply.

To make a claim under the Supplementary Insurance this form should be **fully** completed by you, the patient (except for dental injury – see below), to avoid any delay in your claim being processed. The claim form must reach DPAS Limited within 30 days of the dental injury or emergency; 60 days if emergency treatment is outside the UK.

EMERGENCY CLAIMS: EMERGENCY TREATMENT AWAY FROM HOME

- If you have paid the dentist's account please enclose the original receipt. In this instance the dentist's signature is not required on page four.

INJURY CLAIMS

- When claiming for dental injury please ask your dentist to complete the details of any initial and planned treatment on page three
- The treating dentist must sign the declaration on page four
- **You may not claim more than £225 without obtaining prior approval from DPAS in writing. Photos and/or x-rays, taken before treatment commences, must accompany your claim.**

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: _____

Are you covered by, or claiming under, any other insurance in relation to this incident? ❍ Yes ❍ No

Details if yes: _____

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

If yes, please give details and dates: _____

_____

YOUR REGISTERED DENTIST DETAILS

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

Practice Name: _____

Address: _____

_____ Postcode: _____

Practice phone: _____ E-mail: _____

YOUR TREATING DENTIST/CONSULTANT DETAILS (if different from above)

If you are a registered DPAS dentist, please complete the practice reference number: _____

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

Practice Name: _____

Address: _____

_____ Postcode: _____

Practice phone: _____ E-mail: _____

Claim information

EMERGENCY CLAIM

How did your dental emergency occur? _____

_____

Date and time of emergency treatment: _____

What treatment/advice was given? _____

_____

_____

If you were abroad: Date of leaving the UK: _____ Date of return to the UK: _____

Did you contact the DPAS Dental Emergency Helpline? ❍ Yes ❍ No

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

Have you incurred a call out fee? ❍ Yes ❍ No If yes, call out fee: £ _____

You may claim emergency treatment costs if away from home or for dental injury. Please provide details of the treatment below:

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Resecure crown	18	£29.20

PROCEED TO PAGE FOUR (If claiming for emergency only)

INJURY CLAIM

Date and time of incident: _____ Incident place: _____

How did your dental injury occur? _____

_____

What damage did you notice within seven days of the incident? _____

_____

Were there any witnesses? ❍ Yes ❍ No

If yes, please give names and addresses: _____

_____

_____

Was the incident reported to anyone in authority, such as your employer or the police? ❍ Yes ❍ No

If yes, please give the person's name and details: _____

_____

_____

Were any existing implants damaged? ❍ Yes ❍ No

Do you have a DPAS Dental Implant Accident Protection Policy? ❍ Yes ❍ No

If yes, please provide your policy number: _____

PROCEED TO PAGE THREE

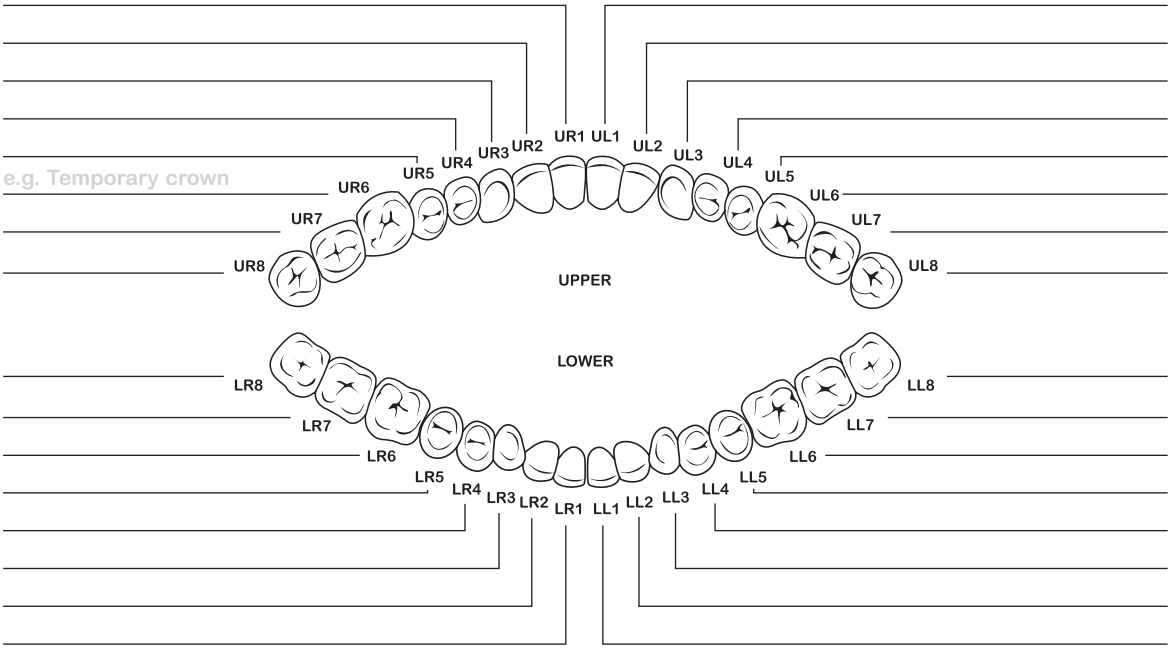
Treatment information – dental Injury

Please ask your dentist to complete this section of the claim form.

Date treatment started: _____ Date treatment completed: _____

Please indicate on the diagram below:

❍ Details of pre-existing conditions i.e. existing bridge/crown etc ❍ Injury sustained, and to which teeth



What treatment has been given?

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Temporary crown	20	£53.30
		TOTAL	

If ongoing treatment is required, please give details of planned treatment and expected costs:

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Crown – Porcelain jacket	6	£300
		TOTAL	

I have enclosed the required x-rays and/or photos ❍ **Yes** ❍ **No**

If no, please state reason: _____

_____

Additional notes: _____

PROCEED TO PAGE FOUR

Payment information

PLEASE ENCLOSE ORIGINAL RECEIPTS IF YOU HAVE ALREADY PAID THE DENTIST'S ACCOUNT.

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** – Account details are not required for DPAS dentists, as payment will be made directly to the bank account as shown on our records
- ❍ **Treating dentist/consultant**

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:** _____

If patient has receipt for emergency treatment overseas/away from home, a dentist 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 (or 60 days in the case of emergency treatment received outside the UK) of the incident 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