

DENTIST/CONSULTANT'S CERTIFICATE

Are you the patients registered dentist? YES/NO. If NO, are you on the emergency rota?

I certify that the details of treatment (or where relevant, admission to hospital) given above are correct.

Signature:

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

If you are claiming for hospital cash and are unable to obtain the consultant's signature, your dentist may be willing to sign this certificate.

PATIENT'S DECLARATION - ALL PATIENTS MUST SIGN. (However, if patient is under 18 years, to be completed by the parent/guardian)

I warrant the truth of the information given above. I understand that the issue of this form is not an admission of my claim. I am also aware that DPAS 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 LTD 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 LTD. 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.

Where 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 information abroad and to receive on their behalf any data protection notices.

Signature:

Name (parent/guardian): **Date:**

Completed form to 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 LTD, Fonthill Bishop, Salisbury, Wiltshire SP3 5SH

DPAS is an appointed representative of ACE European Group Limited, which is authorised and regulated by the Financial Services Authority

Further notes:

FOR OFFICE USE ONLY

REF:

APP:

SD:

LP:

BACS CHQ

**DENTAL ACCIDENT & EMERGENCY INSURANCE CLAIM FORM**

Reading the information about this insurance in your dentist's explanatory leaflet will help you complete this form.

If you are making a claim for the cost of treatment, it will be helpful if you can get your dentist (or, in the case of emergency treatment, the dentist who provided it) to sign the certificate on page 4 and fill in the treatment details. If for any reason you cannot do this, do not delay in returning the form; **to be valid the claim form must reach DPAS within 30 days of the claim incident (or 60 days if emergency treatment outside the UK).**

Please note that **you are not covered for emergency treatment if you could have reasonably accessed your own dentist's emergency arrangements.**

If you are claiming for **dental injury**, please note that **you may not claim more than £175 without getting prior approval from DPAS. Photos &/or X-rays, taken before treatment commences, must accompany the claim.**

PLEASE COMPLETE USING BLOCK CAPITALS. THE FORM MUST BE FULLY COMPLETED TO ENABLE THE CLAIM TO BE PROCESSED.

YOUR DETAILS

Title: Forenames: Surname: Date of birth:

Address:

Postcode:

Home telephone number:
I note DPAS LTD may contact me, if necessary.
Daytime telephone number:
Practice plan registration number:

Have you made any previous claims under any dental insurance policy?

If YES, please give details and dates:

DETAILS OF TREATING DENTIST

If you are a DPAS LTD Registered Dentist **PRACTICE NO:**

Title: Forenames: Surname:

GDC number: Practice telephone number:

Practice address:

Postcode:

continued overleaf ⇨

DENTAL INJURY (Part A) – please complete this part yourself

Date of incident: Time: Place:

How did your dental injury occur?

What damage did you notice within 7 days of the incident?

Were there any witnesses? **YES/NO** If **YES**, please give names and addresses

Are you covered by, or claiming under, any other insurance in relation to this incident? **YES/NO** If **YES** please give details

Was the incident reported to anyone in authority, such as your employer or the police? **YES/NO** If **YES** please give details, including any reference

Do you wish DPAS to pay the practice/dentist directly? YES / NO
(if NO, please forward dentist's account on completion of treatment to DPAS Ltd.)

DENTAL INJURY (Part B) – if possible, please ask the dentist to complete this part

Details of pre-existing conditions

What injury was sustained and to which teeth?

Date treatment started: Date treatment completed:

What treatment has been given?

Treatment item number *

Cost of treatment £ £ £ £ £

Total cost of treatment £ Cheque payable to (if practice/dentist to be paid directly)

Please Note: Payment to DPAS dentists will be made directly into their bank, via direct transfer.

What further treatment is planned and costs, if not included above? (continue overleaf or on a separate sheet if necessary)

* For treatment item numbers, see the list in your dentist's explanatory leaflet.

EMERGENCY TREATMENT

Date of treatment or consultation: Time of treatment or consultation:

Did the dentist have to open his or her surgery to treat you? YES/NO Did you contact the **First Assist** Dental Emergency Helpline? YES/NO

In what circumstances did the need for emergency treatment arise?

Please describe the treatment and/or advice given (if possible, please ask the dentist to complete this box)

Treatment item number *

Cost of treatment £ £ £ £ £

Total cost of treatment £ Dental Helpline ref. number Call out fee £

Are you covered by, or claiming under, any other insurance in relation to this incident? YES/NO
If **YES** please give details

Have you paid the dentist's account? If **YES**, please attach the original receipt YES / NO

IF YES: Cheque payable to :

If NO, do you wish DPAS to pay the practice / dentist directly YES / NO

Cheque payable to practice/dentist YES / NO

Please Note: Payment to DPAS dentists will be made directly into their bank, via direct transfer.

* For treatment item numbers, see the list in your dentist's practice leaflet.

HOSPITAL CASH / MOUTH CANCER

Date of admission to hospital Time of admission to hospital

Date of discharge from hospital Time of discharge from hospital

Name and address of hospital:

Name of consultant under whose care you were admitted:

Reason for admission to hospital:

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