

C Registered Dentist Details

Name of Dentist you are registered with	<input type="text"/>	Practice Type:
Practice Name	<input type="text"/>	<input type="checkbox"/> NHS
Address	<input type="text"/>	<input type="checkbox"/> Private
	<input type="text"/>	
	<input type="text"/>	Post Code <input type="text"/>
Telephone No.	<input type="text"/>	

NOTE - You need to have been seen by a dentist in the 12 months before the Start Date in order to be covered for dental treatment. If that dentist is not the dentist above please provide details in Section F of the claim form.

D Declaration and Authorisation

I declare that the statements I have made are true and I agree that if they are found to be untrue, I will lose all my rights under the policy. I authorise Red Sands Insurance Company (Europe) Limited, Dencover Limited and any of their representatives to make any enquiries and obtain any information they may consider relevant from me, my dentist, or elsewhere.

Access to Medical Reports Act 1988 – prior to your Dentist completing Part E, you must give your consent in relation to Dencover Limited's representative accessing your Medical reports. Prior to you providing this consent, your rights under the Access to Medical Reports Act 1988 are summarised below;

- You do not have to provide your consent.
- You have the right to ask to see the report for up to 6 months after the report is completed.
- You have the right to ask to see the report before it is issued by the dentist (but only for 21 days starting from the date of the report).
- You have the right to ask your dentist to change any part of the report, which you believe to be inaccurate or misleading. The dentist may not be willing to agree to your requested change, if this is the case, then you should attach your comments to the report.
- If the dentist is concerned that if you see the report it may physically or mentally harm you, the dentist may withhold all or any part of the report from you.

I am now aware of my rights under the Access to Medical Reports Act 1988.

- I provide my authorisation for Dencover Limited's representative to request a medical report from my dentist. I understand that the report will include my dental history, nature of my conditions and / or its treatment.
- I **do / do not (delete as required)** want to see the report before it is issued by the dentist. If you do not 'delete as required', we will assume you do not want to see the report before it is issued by the dentist.
- I provide my authorisation for the dentist to provide such information to Dencover Limited, Red Sands Insurance Company (Europe) Limited and their representatives.

I understand that my personal information will be held on computer or other files by Red Sands Insurance Company (Europe) Limited, Dencover Limited, Direct Group Limited and any associated company or agent for the purposes of administering this insurance, including carrying out customer surveys, claims handling and fraud prevention. I consent to my personal information being disclosed to Direct Group Limited, and also to other insurers via claims registers used by the insurers to stop people making dishonest claims. (A list of insurers who take part in the registers is available on request).

I understand that it is my responsibility to give all necessary information to the Tax Authorities and to meet any tax demands I may have from my claim being paid.

Patient Signature

Date / /

PLEASE COMPLETE THE FOLLOWING SECTIONS IF APPLICABLE:

I certify that I supplied dental treatment to:

Patient's Name

on: / /

Date patient first registered at the practice: / /

Date of last three check-ups: (1) / / (2) / / (3) / /

Date treatment first identified as being medically necessary: / /

MAINTENANCE

TREATMENT	QUANTITY	TOTAL COSTS (£)
Routine examination		
Hygiene treatment (inc. Scale/Polish)		
Dental x-ray		
TOTAL		£

PROCEDURAL WORK

TREATMENT	QUANTITY	TOTAL COSTS (£)
Filling		
Crown		
Bridge or denture		
Root canal		
Simple extraction		
Surgical extraction		
TOTAL		£

ACCIDENT

a sudden and unexpected identifiable external blow to the mouth that happens by chance, which causes significant dental injury to the teeth or gums (or both), resulting in medical or dental attention within 48 hours of the incident.

TOTAL	£
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EMERGENCY

a single initial dental appointment that you urgently need outside of practise hours to get immediate treatment for any of the following: severe pain, trauma to your teeth or mouth, including trauma that prevents you eating, acute infection(s) or stopping bleeding after a tooth has been taken out.

TOTAL	£
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HOSPITAL DENTAL COVER

Number of nights (£50 per overnight stay)	
TOTAL	£

ORAL CANCER

TOTAL	£
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DENTIST SIGNATURE

**This must be signed by the dentist not a practice representative

Signature**

Dentist Name

Practice Telephone No.

Dentist's Practice Stamp

Date / /

F Previous Dentist History

If you are required to provide previous dentist history as per the requirement detailed in Section C, please complete the sections below:

Name of Dentist you were previously registered with

Practice Name

Address

Post Code

Telephone No.

Date of last check-up:

G Next Steps

PLEASE CHECK:

- You have provided the policyholder details in section (A)
- You have provided patient details (if different to policyholder) in section (B)
- You have provided your registered dentist details in section (C)
- You have signed the declaration and authorisation in section (D)
- Your dentist has completed all relevant sections in section (E)
- Your dentist has signed, dated and stamped section (E)
- You have provided additional information on previous dentists (if required) in section (F)
- You have attached original itemised receipt(s)

Tick Box

IMPORTANT NOTICE:

- You must complete and submit the claim form within 30 days of the dental treatment, even if you are on a long term treatment plan. Failure to do so could result in your claim not being accepted.
- We will process claim forms within 10 working days.

PLEASE RETURN THIS CLAIM FORM TO:

Dencover Claims Department, Direct House, 4 Sidings Court, Doncaster, South Yorkshire DN4 5NU.

SHOULD YOU HAVE ANY PROBLEMS READING OR COMPLETING THIS FORM PLEASE CONTACT OUR CLAIMS DEPARTMENT ON:

0845 123 1078

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