

# DENTAL CLAIM FORM

## IMPORTANT

PLEASE COMPLETE ONE CLAIM FOR EACH CLAIMANT

- Your Policy document will tell you whether or not you can make a claim.
- Make sure you answer all the questions on this form; otherwise it will delay your claim.
- Please ensure that you provide original detailed receipts.

OFFICE USE ONLY – CLAIM NO.

## A Personal Details

### CLAIMANT

Policy Number

Title Mr.  Mrs.  Miss  Ms  Other

First Name(s)

Surname  Date of Birth  /  /

Address   
  
  
 Post code

Home Telephone

Work Telephone

Mobile Telephone

E-mail Address   
 @

Mother's maiden name

## B Policyholder – (please complete if you are not the patient)

Title Mr.  Mrs.  Miss  Ms  Other

First Name(s)

Surname

Date of Birth  /  /

Relationship to you

## C Data Protection

Except as authorised in the Declaration below, Red Sands Insurance Company (Europe) Limited, or their representatives, will not discuss your claim with anyone else without your permission. This includes your spouse, any relative or friend, or your legal advisor. If you want to give us permission to talk to another person, please state their name and their relationship to you below. Please note that for your security we will ask them to confirm their identity by confirming YOUR date of birth, postcode and mother's maiden name.

Name

Relationship

**D Dental Practice Receipt**

Please attach the original dated receipt(s)

I certify that I supplied dental treatment to:

Patient's name on:  /  / **IF APPLICABLE:**

I certify that the following costs were incurred as a result of:

Date patient first registered at the practice:  /  / Date treatment first identified as being medically necessary:  /  /  **A dental accident***(a sudden and unexpected injury to the mouth which causes damage to teeth/or gums and results from direct violent means)*£  **Emergency dental treatment \****(initial visit only for the immediate relief of severe pain, the inability to eat, arrest of a haemorrhage, control of acute infection or which causes a severe threat to your general health)*£ 

\*Please note emergency dental treatment is classed as treatment that must be provided out of hours or by a dentist other than your normal dentist as a result of you being more than 25 miles by road from your normal dentist when the emergency occurs. Any subsequent treatment required or received is excluded unless cover is specifically provided for under any section of the policy.

| CATEGORY  | TREATMENT                  | QUANTITY | TOTAL NHS COSTS (£)    | TOTAL PRIVATE COSTS (£) |
|-----------|----------------------------|----------|------------------------|-------------------------|
| CHECK-UPS | Examination                |          |                        |                         |
|           | Scale/Polish               |          |                        |                         |
|           | X-Ray                      |          |                        |                         |
| TREATMENT | Filling                    |          |                        |                         |
|           | Crown                      |          |                        |                         |
|           | Bridge                     |          |                        |                         |
|           | Mouth Guard                |          |                        |                         |
|           | Root Canal                 |          |                        |                         |
|           | Simple Extraction          |          |                        |                         |
|           | Surgical Extraction        |          |                        |                         |
| EMERGENCY | Emergency Dental Treatment |          |                        |                         |
|           | Dental Accident Cover      |          |                        |                         |
|           | Oral Cancer                |          |                        |                         |
| TOTAL     |                            |          | £ <input type="text"/> | £ <input type="text"/>  |

Practice Signature  Practice Telephone 

Dentist's Practice Stamp

Date  /  / **E Declaration and Authority**

I declare that the statements I have made are true and agree that if they are found to be untrue, I will lose all my rights under the policy. I authorise Red Sands and any of its representatives to make any enquiries and obtain any information they may consider relevant from me, my dentist, or elsewhere. I understand that my personal information will be held on computer or other files by Red Sands, 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 under the agreement with which I took out with this insurance, and also to other insurers via a register of claims used by the insurers to stop people making dishonest claims. (A list of insurers who take part in the scheme 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.

Signature  Date  /  / **F What to do now**

Make sure that:

- your dental practice has completed and signed Section D;
- you have signed the declaration and authority (Section E);
- you have attached original detailed receipts.

Please return this claim form to us within 30 days of the date of treatment to this address:

**Dencover Claims Department, Direct House, White Rose Way  
Doncaster, South Yorkshire DN4 5NU**

Should you have any problems reading or completing this claim form, please contact our claims department on:

**0845 123 1078**

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