

# Claim for hospital cash benefit

## Supplementary Insurance/Denplan Emergency – Benefit D

Office use only. Claim reference number.

Before completing this form please read the terms and conditions of your policy document. To help us settle your claim quickly please answer all questions as accurately as you can and write clearly in BLOCK CAPITALS using black or blue ink.

Please make reasonable efforts to ask your consultant or dentist to complete the information required concerning any treatment and advice that you've received. If there is any difficulty in doing this, do not delay in returning the form to us.

If you've any questions please call a member of our insurance team free from a UK landline on 0800 085 0960. Please send your completed form, within 60 days of your discharge from hospital where reasonably possible, to us at Insurance Department, Denplan Limited, Denplan Court, Victoria Road, Winchester, Hampshire, SO23 7RG.

### Patient details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Which Denplan product are you registered on?

Denplan Care  Denplan Essentials  Membership Plan  Plans for Children  Denplan Emergency

What is your Denplan registration number?

Mr  Mrs  Miss  Other  Male  Female  Date of birth

First name

Surname

House name or number

Address

Town or city

County  Postcode

Is this your permanent address? Yes  No

Home phone number  Work phone number

Email address

We may use this email address to advise you of confidential information regarding your insurance claim. If you would prefer not to be contacted in this way, please don't provide your email address.

Have you made any previous claims under this Supplementary Insurance/Denplan Emergency policy? Yes  No

### Hospital and treatment details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Date of admission  Time  :  AM  PM  Date of treatment

Date of discharge  Time  :  AM  PM

Please provide the name and address of the hospital where the patient was treated

Postcode

Name of consultant  Specialism

Please give a description of treatment/consultation given

### Consultant declaration

I confirm that the information I have given in respect of hospital admission and nature of treatment are correct.

Consultant's name

Consultant's signature

Date

Contact phone number (in case of subsequent enquiry)

Any costs incurred when obtaining the above signature and medical records are not covered under the terms of the Supplementary Insurance.

### Patient's declaration

To be completed by the patient (or parent/guardian of a patient under 16 years)

I confirm that I am the patient (patient's parent or guardian if under 16 years of age) and I declare that all the information provided on this form is true and complete. I hereby consent to and authorise the General Practitioner and/or any Specialist involved in my/the patient's care to discuss treatment details and discharge arrangements with Denplan Limited. I understand that Denplan Ltd, on behalf of the Insurers, reserves the right to appoint an examiner or make such other enquiries as it considers appropriate before agreeing any claim.

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date

**Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK**

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At the heart of dental care