

Injury/emergency treatment details



Date of incident:

Date of treatment:

How did the incident occur?

Details of treatment:

Cost:

Was the treatment overseas?

Yes No

Call out fees

Date of call out:

Time of call out:

Cost:

Hospital cash benefit

Date of admission:

Date of discharge:

Mouth Cancer cover

Date of diagnosis:

Date treatment completed:

Compensation for complete loss of permanent teeth, following an injury

How many teeth?

Which teeth? (please state)

Incidental expenses

Please provide details of any sundry expenses you are claiming for (please attach all receipts-limit £30) e.g. transport cost to dentist.

Cost:

Total costs £

Policyholder Declaration



I declare that I am the policyholder and that the patient is covered by my policy.

I wish to make a claim on my policy and declare that all the particulars given above are, to the best of my knowledge, true and correct. I confirm that the patient consents to Denplan processing the particulars on this form and in any medical reports or health records that may be requested.

Data Protection Act – you will see this sign where we ask you to give personal information.

To set up and administer your policy Denplan Limited will hold and use information supplied by you and those people included in your application. By signing this form you confirm that you and all those included in your application consent to such use of your personal data. We may also disclose information about anyone included in your application when there is a legal requirement to do so, to people who provide a service to us on the understanding that they will keep the information confidential and in accordance with the Data Protection Act 1998, or in circumstances where it would help us to prevent fraud or improper claims.

Denplan Limited may contact you with details of its other products and services and we may also share some of your details with other companies within the Simplyhealth group to enable them to contact you with details of their products and services.

We may contact you by post, telephone or electronically if appropriate. If you do not wish us to do this, please tick the box otherwise we will assume that, for the time being, you are happy for us to contact you.

Policyholder's signature

Date

Dentist's Declaration



I declare that the injury (if applicable) sustained by this patient is consistent with direct extra oral impact and that the information given above is correct.

Print name

Dentist's signature

Date

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Denplan
At the heart of dental care