

Denplan for Schools Claim Form

Office use only

Claim ref no.

ONCE YOU HAVE COMPLETED THIS FORM PLEASE POST IT TO:

Denplan for Schools, Denplan Court, Victoria Road, Winchester SO23 7RG

Any questions? Call: 0800 214 357 or Email: denplanforschools@denplan.co.uk

Lines are open 8.00am to 5.30pm Monday to Thursday and 8.00am to 4.30pm Friday. Calls may be recorded.

PLEASE READ BEFORE COMPLETING THE CLAIM FORM

- All claim forms should be submitted within 30 days of receiving your course of treatment.
- You must obtain proof of treatment from your dentist, showing a breakdown of treatment costs, and attach it to this claim form.
- Incomplete claim forms, or claim forms without your proof of treatment attached, will be returned.
- Complete a new claim form for each course of treatment.
- The claim form must be signed by the policyholder/guardian and dentist.
- Only one patient per claim form.
- All payments are made by cheque in £ sterling, usually within 10 working days, from receipt of the claim.
- Please refer to your policy handbook for full details of your benefit entitlements.

A. Policyholder details (parent/guardian)

Title:	<input type="text"/>	First name:	<input type="text"/>	Surname:	<input type="text"/>
Address:	<input type="text"/>			Postcode:	<input type="text"/>
	<input type="text"/>			Email address:	<input type="text"/>
Daytime telephone number:	<input type="text"/>				

Patient details (if different from the policyholder)

Title:	<input type="text"/>	First name:	<input type="text"/>	Surname:	<input type="text"/>
Date of birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School/College name:	<input type="text"/>				

Payment details Please tick who the cheque should be made payable to: (please state)

Dentist Policyholder Patient

B. Treating dentist's details

Treating dentist's name:	<input type="text"/>		
Treating dentist's address:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
Postcode:	<input type="text"/>	Telephone number:	<input type="text"/>



C. 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 £

Data Protection Act - you will see this sign where we ask you to give personal information.
 To set up and administer your policy we will hold and use information about you, and any family members covered by your policy, supplied by you or those family members and by medical providers. We may send it in confidence for processing to other companies in the AXA group (or companies acting on our instructions) including those located outside the European Economic Area. By signing this form you and any family members covered by your policy consent to such use of this personal data.
 You may be contacted by post, telephone, or electronically if appropriate. If you do not wish us to do this please tick the appropriate box(es) below.
 Denplan Limited may send you details of our other products and services. To enable them to send you details of their services we may also share some of your details with other AXA group companies based within the European Economic Area and with other carefully selected companies based within the European Economic Area

Policyholder Declaration

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.

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

Policyholder's signature:
(parent/guardian)

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:

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

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