Claim for hospital cash benefit

Supplementary Insurance/Denplan Emergency – Benefit D

Denplan
Part of Simplyhealth

Before completing this form please read the terms and conditions in your policy document. To help us settle your claim quickly please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.
Please ask your consultant or dentist to complete the information required concerning any treatment and advice that you've received.
Please be aware we may need your dental records to support your claim.

If you've any questions please call call 0800 587 6578, or email trauma@simplyhealth.co.uk

Please send your completed form, within 60 days of the incident where reasonably possible, to us at Denplan, part of Simplyhealth, Hambleden House, Waterloo Court, Andover, SP10 1LQ.

Patient details

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

Patient registration number

Mr ◯ Mrs ◯ Miss ◯ Other

Date of birth D D M M Y Y Y Y

First name

Surname

House name or number

Address

Town/City

Postcode

Is this your permanent address? Yes ◯ No ◯

Home phone number

Mobile phone number

Email address

We may use this email address to advise you of confidential information about your insurance claim. If you would prefer not to be contacted in this way, please leave this box blank.
If you would prefer to receive your regular Denplan membership correspondence by email, please tick ◯

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 D D M M Y Y Y Y Time : AM ◯ PM ◯ Date of treatment D D M M Y Y Y Y

Date of discharge D D M M Y Y Y Y Time : AM ◯ PM ◯

If your stay exceeded 5 days, please provide a copy of your admittance and discharge form or any other supporting evidence

Please provide the name and address of the hospital where you were treated

Postcode

Name of consultant

Specialism

Please give a description of treatment/consultation given

Please turn over

Payment details

To be completed by the patient. Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully. We may return the claim form to you if this not completed.

◯ Direct payment into the bank account we debit your monthly subscription from

Or, please make payment for this claim by:

◯ Cheque payable to

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 D D M M Y Y Y Y

Dentist's/Consultant's declaration

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

Consultant's name

Dentist's/Consultant's signature

Date D D M M Y Y Y Y

GMC / GDC number

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.

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