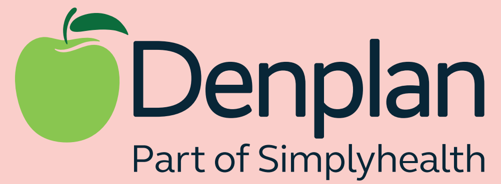
Claim for mouth cancer cover and hospital cash

Supplementary Insurance/Denplan Emergency – Benefit F



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 treating consultant 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

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

Treatment section

To be completed by the Specialist or referring General Practitioner

Please provide the name and address of the hospital where the treatment took place

Hospital name

Hospital address

Postcode

Where is the primary site of the cancer?

On what date did the patient first became aware of the symptoms? D D M M Y Y Y Y

Please describe the treatment provided

What was the date of diagnosis? D D M M Y Y Y Y

Does the treatment relate to tests or consultations for non-invasive tumours? Yes No

Please describe any further treatment may be planned

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 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 Ltd. 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.

I declare that the mouth cancer was not:

- diagnosed before I joined Denplan
- diagnosed within 90 days after the date I was provided with mouth cancer cover, or for which tests or consultations began within those 90 days
- caused as a result of chewing tobacco products, betel nut or prolonged alcohol abuse
- found in the tonsils

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date D D M M Y Y Y Y

Dentist's/Consultant's declaration

I declare that I am the patient's Specialist (or General Practitioner), that the patient was referred to me by his/her General Practitioner, and that the information given is, to the best of my knowledge, true and correct.

Name

Signature

Date D D M M Y Y Y Y

Title

Are you a Consultant Maxillofacial Surgeon? Yes No

If 'No' please give details of your medical specialism

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