

Denplan Claim Form

Office use only

CR _____ A:
 P1: _____ S:
 P2: _____
 P3: _____ CCD: Date: _____ Amount: _____

Once you have completed this form please post it to: Denplan Corporate, Denplan Court, Victoria Road, Winchester SO23 7RG.
For further information about claiming please visit: www.denplan.co.uk **If you have any queries, please do not hesitate to contact us:** Call: 0800 838 951 or Email: corporate@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).

✓ Claiming Checklist
 In order for your claim to go through successfully please make sure you have done the following:

- fill out all the relevant white boxes
- make sure the policyholder signs and dates the claim form NOT the patient or the dentist
- use one claim form per person
- attach an itemised receipt showing proof of payment and a breakdown of the treatment
- If you have received NHS treatment or emergency treatment, please make sure this is clearly stated on your itemised receipt

Please note: We cannot accept a treatment plan and if any of the above has not been completed, your claim may be returned or the assessment delayed. If the receipt is not written in English, your claim may take longer to assess due to translation, so please bear with us. Please make sure you submit your claim form within 60 days of treatment. Denplan will process your claim and send payment within five working days (providing we receive full information about your treatment).

i Policyholder/Patient details

Policy number: _____ Company name: _____

Policyholder details (employee of the company):

Date of birth: Title: _____

First name: _____ Surname name: _____

Address: _____

Postcode: _____

Phone number: (Daytime) _____ (Evening) _____

Email: _____ (Personal)

Patient details (if different from the policyholder):

Date of birth: Title: _____

First name: _____ Surname name: _____

Please tick who the cheque should be made payable to: **Policyholder:** **Patient:**

i Routine/restorative treatment details

Please list all treatment details, e.g. examination, hygiene treatment, x-ray, filling, inlay, crown, bridge, denture, etc.

	NHS	Private	Overseas	Date						Amount Paid
e.g examination (band one)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0	1	0	4	0	8	£16.20
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D	D	M	M	Y	Y	
Total Amount Paid:										

Dental injury/emergency treatment details

Please tick whether it was an dental injury or emergency treatment:

Injury

Emergency

Date of dental injury/emergency:

D D M M Y Y

What type of treatment did you receive:

NHS

Private

Overseas

Treatment details:

Date of treatment: D D M M Y Y Amount Paid:

Call out fees: Time: Date of call out: D D M M Y Y Amount Paid:

Total Amount Paid:

Please tick the below if they apply to you:

If the injury/emergency was a result of a contact sport: Yes No

If yes, were you wearing a mouth guard: Yes No

Other treatment details

Hospital cash benefit: Date of admission: D D M M Y Y Date of discharge: D D M M Y Y

Mouth cancer cover: Date of diagnosis: D D M M Y Y Date of treatment: D D M M Y Y

Treating dentist's details

Please inform your dentist if you are claiming through Denplan. This will enable them, to disclose important information to us regarding treatment details and your dental records. This will help your claims process go through quicker.

Dentist's name:

Practice name:

Address:

Postcode:

Phone number:

Declaration

I declare that I am the policyholder.

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 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 signature:

Date: D D M M Y Y

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