Accident & Emergency Dental Cover Claim Form

- Please refer to the policy wording for full details of cover and conditions
- Please complete **ALL** relevant sections on **BOTH PAGES** of this claim form in **BLOCK CAPITALS**
- Ensure this form is signed and all relevant receipts are attached
- Forward to: **Lloyd & Whyte Ltd**, **Affinity House**, **Bindon Road**, **Taunton**, **Somerset**, **TA2 6AA** or scan and email the form to **flexiplan@lloydwhyte.com**
- Should you have any queries please ring **Lloyd & Whyte Ltd** on **01823 250709**

Lloyd & Whyte Use Only
Client Code:

Privacy & Data Protection
The data controller in relation to any personal data you supply is Hamilton Insurance DAC.
How the Insurer uses your/the plan members' personal data and who they share it with
The Insurer may use the personal data they hold about You/the Plan Member for the purposes of providing insurance, handling claims and any other related purposes (this may include underwriting decisions made via automated means), for offering renewal terms, research or statistical purposes and, if they have consent to do so, to provide You with information, products or services that You request from them or which they feel may interest You. They will also use Your/the Plan Member's data to safeguard against fraud and money laundering and to meet their general legal or regulatory obligations.
Sensitive personal data
Some of the personal information, such as information relating to health or criminal convictions, may be required by the Insurer for the specific purposes of underwriting or as part of the claims handling process. The provision of such data is conditional for them to be able to provide insurance or manage a claim. Such data will only be used for the specific purposes set out in their notice.
Disclosure of your/the plan/the plan member's personal data
The Insurer may disclose Your/the Plan Member's personal data to third parties involved in providing products or services to them, or to service providers who perform services on their behalf. These include their group companies, affinity partners, brokers, agents, third party administrators, reinsurers, other insurance intermediaries, insurance reference bureaus, credit agencies, medical service providers, fraud detection agencies, loss adjusters, external law firms, external auditors and accountants, regulatory authorities, and as may be required by law.
International transfers of data
The Insurer may transfer Your/the Plan Member's personal data to destinations outside the European Economic Area ("EEA"). Where they transfer Your/the Plan Member's personal data outside of the EEA, they will ensure that it is treated securely and in accordance with the Legislation.
Please visit www.hamiltongroup.com for further privacy notice information and full contact details of the data protection officer.

Policyholder Details (The Practice)

I have carried out (or verified) the completion of the Treatment as detailed below (please ensure a receipt is attached).

Practice Name	Patient Reference No. (if known)
Dentist's Name	Date of Treatment DD MM YYYY
Signature	Date Signed DD MM YYYY

Plan Member Details (The Patient)

I am a registered patient of the Dentist shown above and understand that the Treatment as detailed below has been carried out and claim repayment of fees paid by me (or to the practice directly) as indicated below.

Patient Title (circle as appropriate) Mr / Mrs / Miss / Ms / Other (please state)	Date of Birth DD MM YYYY
Patient Name	Date of Incident DD MM YYYY
Patient Address Postcode	Patient Signature
Email	Date Signed DD MM YYYY

Patient / Practice BACS Payment Details

Bank Name & Address	Payable to: (Please tick as appropriate) ☐ Practice ☐ Patient
	Bank Account No
	Sort Code

Section 1 - Emergency Treatment Benefit

Description and reason for emergency Treatment (required) Cost of Treatment (prior to deduction of £10 excess) £ .	Location of Treatment
	Time & Date of Emergency Call-out (if applicable)

Reason why patient couldn't attend Registered Practice during published opening hours: (To be completed by the Registered Practice)

Section 2 - Treatment Following Accident

Code	Treatment received (please tick)	Tooth Number(s)	Maximum limit	Cost	Description of Accident or Injury
2092	☐ Porcelain jacket crown		£500 per crown	£ .	
2091	☐ Ceramic bonded crown		£500 per crown	£ .	
2010	☐ Examination and report to include all necessary smoothing, polishing and vitality testing		£50 per incident	£ .	
2020	☐ X-rays		£40 per incident	£ .	
2123	☐ Post/core construction		£110 per tooth	£ .	
2091	☐ Zirconia crown		£540 per unit	£ .	
2097	☐ Zirconia bridge unit		£540 per unit	£ .	
2093	☐ Metal bonded porcelain crown		£475 per unit	£ .	
2102	☐ Bonded metal/porcelain bridge work		£470 per retainer £435 per pontic	£ . £ .	
2090	☐ Full metal crown		£450 per unit	£ .	
2103	☐ All metal bridge work		£470 per retainer £435 per pontic	£ . £ .	
2098	☐ Laboratory constructed adhesive bridge		£285 per retainer £300 per pontic	£ . £ .	
2083	☐ Laboratory constructed adhesive facing or veneer		£445 per unit	£ .	
2112	☐ (i) Permanent denture acrylic		£500 per denture	£ .	
2116	☐ (ii) Permanent denture metal		£775 per denture	£ .	
2170	☐ Temporary denture following tooth loss where required		£305 per incident	£ .	
2094	☐ (i) Laboratory made temporary bridge following tooth loss (where required)		£185 Up to 3 units	£ .	
2094	☐ (ii) Additional units		£60 per unit	£ .	
2001	☐ Emergency and other Treatment following dental injury not otherwise specified		£620 per incident	£ . £ .	
2061	☐ (i) Root canal Treatment incisor		£320 per incisor	£ .	
2061	☐ (ii) Root canal Treatment canine		£320 per canine	£ .	
2062	☐ (iii) Root canal Treatment premolar		£320 per premolar	£ .	
2063	☐ (iv) Root canal Treatment molar		£500 per molar	£ .	
2135	☐ Implant		£2100 per tooth	£ .	

Section 3 - Hospital Benefit

Please enclose a hospital discharge form. In normal circumstances payment will be made to the Patient.

Description of accident or event that resulted in dental trauma

Location of Hospital / Specialist

From (Date & Time)
DD MM YYYY HH : MM

To (Date & Time)
DD MM YYYY HH : MM

Section 4 - Oral Cancer Benefit

Please enclose the full diagnosis from the Specialist. In normal circumstances payment will be made to the Patient.

Diagnosis

Location of Hospital / Specialist

Date of Diagnosis DD MM YYYY

Section 5 - Permanent Facial Disfigurement

Please enclose the full diagnosis from the Specialist. In normal circumstances payment will be made to the Patient.

Diagnosis (please tick)	Amount Payable
☐ Scarring up to 5 cms long in total length	£55
☐ Scarring more than 5 cms but less than 8 cms in total length	£110
☐ Scarring 8 cms or more in total length	£550

Location of Hospital / Specialist

Date of Diagnosis
DD MM YYYY