

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
- Should you have any queries please ring Lloyd & Whyte Ltd on 01823 250700

Lloyd & Whyte Use Only
Client Code:

Data Protection Act (1998) - Use of your information

Information you supply may be used for the purposes of insurance administration by the insurer its association companies and agents, by re-insurers and your intermediary. It may be disclosed to regulatory bodies for the purpose of monitoring and/or enforcing the insurer's compliance with any regulatory rules/codes. Your information may also be used for offering renewal, research, statistical purposes and crime prevention. It may be transferred to any country, including countries outside the European Economic Area for any of these purposes and for systems administration. In assessing claims made the insurer or its agents may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy or repossessions). Information may also be shared with other insurers either directly or via those acting for the insurer such as loss adjusters or investigators. With limited exceptions and on payment of the appropriate fee, you have the right access and if necessary rectify information held about you. In order to assess the terms of the insurance contract or administer claims which may arise, the insurer may need to collect data which the Data Protection Act defines as sensitive (such as medical history or criminal convictions). By proceeding with this claim you will signify your consent to such information being processed by the insurer or their agents.

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

Insured Person 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	Patient Signature
Postcode	Date Signed DD MM YYYY

Section 1 - Emergency Treatment Benefit

We will pay for Emergency Treatment up to the maximum value of £200 per incident, related to Treatment within the UK or £400 for Treatments received outside of the UK provided that such Treatment is received by the Insured Person during the Period of Cover. An excess of £15 is applicable to each and every incident. Treatments will be covered where the Insured Person requires Treatment away from their Registered Practice (after making all reasonable efforts to attend their Registered Practice), or at their Registered Practice outside of their published opening hours. All charges must be reasonable, fair, clinically necessary and in line with the normal published treatment charges of the dental practice.

Description of Treatment	Location of Treatment
Cost of Treatment (prior to deduction of £15 excess) £ .	Time & Date of Emergency Call-out (if applicable)
	Payable to: (Please tick as appropriate) <input type="checkbox"/> Practice <input type="checkbox"/> Patient

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

Section 2 - Treatment Following Accident

A £15 excess shall apply to each and every claim (please indicate full cost of Treatment prior to deduction of Excess). Treatment must have been undertaken at the Practice. Refer any cases over £400 to Lloyd & Whyte Ltd prior to Treatment. In normal circumstances payment will be made to the Practice.

Treatment received (please tick)	Maximum limit	Cost	Description of Accident or Injury
<input type="checkbox"/> Porcelain Jacket Crown	£420 per unit	£ .	
<input type="checkbox"/> Ceramic bonded crown	£480 per unit	£ .	
<input type="checkbox"/> Metal bonded porcelain crown	£475 per unit	£ .	
<input type="checkbox"/> Bonded metal/porcelain bridge	£455 per retainer £400 per pontic	£ . £ .	
<input type="checkbox"/> Full metal crown	£435 per unit	£ .	
<input type="checkbox"/> All metal bridge work	£325 per retainer £300 per pontic	£ . £ .	
<input type="checkbox"/> Laboratory constructed adhesive bridge	£230 per retainer £230 per pontic	£ . £ .	
<input type="checkbox"/> Laboratory constructed adhesive facing / veneer	£425 per unit	£ .	
<input type="checkbox"/> Permanent denture acrylic	£450 per denture	£ .	
<input type="checkbox"/> Permanent denture metal	£660 per denture	£ .	
<input type="checkbox"/> Temporary denture following tooth loss	£275 per incident	£ .	
<input type="checkbox"/> Laboratory made temporary bridge following tooth loss	£180 up to 3 units Additional units £60	£ . £ .	
<input type="checkbox"/> Emergency & other treatment following dental injury not otherwise specified	£600 per incident	£ .	
<input type="checkbox"/> Root canal treatment incisor	£315 per incisor	£ .	
<input type="checkbox"/> Root canal treatment canine	£315 per canine	£ .	
<input type="checkbox"/> Root canal treatment premolar	£315 per premolar	£ .	
<input type="checkbox"/> Root canal treatment molar	£385 per molar	£ .	
<input type="checkbox"/> Implant	£2,100 per tooth	£ .	

Section 3 - Hospital Benefit

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

Description of Treatment	From (Date & Time)
	DD MM YYYY HH : MM
Location of Hospital / Specialist	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	Location of Hospital / Specialist
<input type="checkbox"/> Scarring up to 5 cms long in total length	£55	
<input type="checkbox"/> Scarring more than 5 cms but less than 8 cms in total length	£110	
<input type="checkbox"/> Scarring 8 cms or more in total length	£550	
		Date of Diagnosis
		DD MM YYYY