Supplementary worldwide dental accident and emergency
Claim Form for Redundancy

This claim should be completed to claim under section 5 (Redundancy) of the policy. If your claim falls under another section of the worldwide dental accident and emergency cover, please complete the specific claim form accordingly, available from your registered dental practice.

How to complete and submit your claim form

Please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

This form, countersigned by the registered dentist must be sent to the Insurance team at PPD within 60 days of your redundancy. We will reimburse the costs of your dental plan up the limits shown in this scheme. We will settle the claim directly to your dentist. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist. You must provide all necessary reports, receipts, and other documentation in support of the claim when asked to do so.

Reference to the policy wording will assist you in completing this form. If you have any questions regarding making a claim please contact your dental practice or call the claims help line on 01482 213 215

Please return scans of completed claim forms by email to: ppd@jelf.com

Alternatively, please post hard copies to: Patient Plan Direct Claims Partnership House Priory Park East Hull HU4 7DY

IMPORTANT – The most we will pay is £15 per month for any dental plan for you which does not include your dependants, or £60 per month for any dental plan for you which includes your dependants. We will not make any payment for the first 30 days that you are unemployed and we will not pay for longer than 12 consecutive months.

Patient Details

Full name	
Date of Birth	
Address	
Postcode	
Telephone number(s)	/
Email Address	
Plan reference number *(available from your registered practice)*	

Your Registered Practice Details

Dentist name	
Practice	
Practice Address	
Postcode	
Telephone number	
Email Address	

Redundancy Details

Please advise the date that you were first made aware of possible redundancy?	
Please advise your employment status immediately prior to being made redundant?	

- ✓ **Please provide us with a formal letter from your employer confirming the redundancy.**
- ✓ **Please provide us with documentary evidence to confirm that you are actively seeking alternative employment e.g. evidence of your attendance at your local job centre**
- ✓ **Please provide us with documentary evidence to show that you are in receipt of unemployment benefit per calendar month.**

Payment Details

We will reimburse the costs of your dental plan up the limits shown in this scheme. We will settle the claim directly to your registered dental practice. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist.

Using your personal information

We collect and process information about you in order to provide insurance policies and to process claims. Your information is also used for business purposes such as fraud prevention and detection and financial management. This may involve sharing your information with, and obtaining information about you from, our group companies and third parties such as brokers, loss adjusters, credit reference agencies, service providers, professional advisors, our regulators or fraud prevention agencies. For further information on how your information is used and your rights in relation to your information please request to review a copy of our privacy policy.

Patient Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name		**Signature**		**Date**	

Dentist Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name		**Signature**		**Date**	