Supplementary worldwide dental accident and emergency

Claim form for Hospital Benefit OR Mouth Cancer

This claim form should be completed to claim under section 3 (Hospital Benefit) or section 4 (Mouth Cancer) 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 treating dentist or medical practitioner must be sent to the Insurance team at PPD within 30 days of your admission or diagnosis. Costs or fixed benefits will be reimbursed up to the limits shown in the Policy. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist / hospital. 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

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	

Treatment details

Date & Time of admission	
Date & Time of discharge	
Date of Treatment	
Hospital address	
Full Name of Consultant or Specialist	
Consultant or Specialist Telephone number	
Consultant or Specialist Email Address	
Please provide details of any treatment provided	

If Mouth Cancer has been diagnosed, please detail:

- **Date of diagnosis**
- **Where is the primary site of the cancer?**
- **Is the tumour non-invasive?**

Payment Details

IMPORTANT – We will require a copy invoice detailing any treatment and care fees in order to reimburse these costs. In the instance of a mouth cancer diagnosis we will require to see proof of such diagnosis before making a fixed benefit payment.

Payment will be transferred to your bank account from where regular plan fees are collected.

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 or Medical Practitioner 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**