

HOW TO COMPLETE THIS FORM

Make sure that:

- you have asked your dentist to complete their part of this claim form
- you have decided whether to appoint someone to help with your claim
- you have signed the declaration and authority at the end of this form;
- where requested, you have attached original detailed receipts.

Make sure that you return this claim form within 30 days of the date of treatment to:

Compass Underwriting Ltd, Claims Dpt, 1-2 Crutched Friars, London EC3N 2HT.

we always recommend that you send your documents to us by recorded delivery

Should you have any problems reading or completing this claim form please contact us and one of our staff will be happy to help you.

Email: info@compassuw.co.uk Web: www.compassuw.com

Tel: 0800 319 6601 Fax: 020 7398 0109

IMPORTANT: PLEASE COMPLETE ONE CLAIM FORM FOR EACH CLAIMANT OR CLAIM

- Your copy of the policy document will tell you whether you can make a claim.
- Make sure you answer all the questions on this form, otherwise it could delay your claim.
- Please ensure that you provide original detailed receipts.

OFFICE USE ONLY CLAIM NUMBER

1. Details about Yourself

CLAIMANT

Policy number

Title

Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Miss	<input type="checkbox"/>	Ms	<input type="checkbox"/>	Other	<input type="text"/>
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First name(s)

Last name

Date of Birth

D	D	M	M	Y	Y
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Address

Postcode

Home telephone	Work telephone	Mobile telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email address

2. Policyholder - (please complete if patient is not yourself)

Title

Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Miss	<input type="checkbox"/>	Ms	<input type="checkbox"/>	Other	<input type="text"/>
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First name(s)

Last name

Date of Birth

D	D	M	M	Y	Y
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Relationship to you

Dental Claim Form

3. Dental Practise Receipt - to be completed by your dentist

PLEASE ATTACH ORIGINAL DATED RECEIPT(S)

This section may be completed by your dental practise unless they have provide a full set of invoices/receipts. If so, please attach them to this form.

I certify that I examined and supplied dental treatment to:

Patient's name

Treatment date

from: To: If applicable

CATEGORY	TREATMENT	QUANTITY	TOTAL NHS COSTS (£)	TOTAL PRIVATE COSTS (£)
CHECK-UPS	Examination			
	Scale/Polish			
	X-Ray			
TREATMENT	Filling			
	Crown			
	Bridge			
	Mouth Guard			
	Root Canal			
	Simple Extraction			
	Surgical Extraction			
	Emergency			
EMERGENCY	Emergency Dental Treatment			
	Dental Accident Cover			
	Oral Cancer			
		TOTAL	£	£

Additional Information or Comments

I certify that the following costs were incurred as a result of:

Dentist's practise stamp

- Preventative**
(check-ups, scale/polish, x-rays)
- Treatment**
(fillings, crowns, bridges, dentures, root canal treatment, extractions, cancer)
- Dental Accidents**
(unexpected injury, damage to teeth/gums)
- Emergency Treatment**
(relief for severe pain, acute infection)

Dentist's telephone

Dentist's facsimile number

Dentist's email address

Dental Practise Authorised Signature

Date

4. Release of Medical/Dental Records

CONSENT FORM FOR RELEASE OF DENTAL/MEDICAL RECORDS

We may need to obtain medical/dental reports to support your application/claim. Before we can ask any Dentist or Doctor (only if applicable to your claim) that you have consulted to complete a report, we require your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

You do not need to give your permission but, if you do not, we will be unable to proceed with your claim.

You can ask to see the report before the doctor/dentist returns it to us. If this is the case we will ask the doctor/dentist to keep the report for a period of 21 days for you to arrange to see it. If you have not made arrangements to see the report within this time, your doctor/dentist will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor/dentist for a copy within six months of it being sent to us. We can send a copy of the report to your doctor/dentist if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor/dentist to amend it. If your doctor/dentist refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor/dentist can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor/dentist fills in asks about the following:

- Your current health
Any care, medication or treatment you are currently receiving
The results of referrals or tests you are waiting for
- Any time off work in the last three years, if applicable
- Your past health
Details of any relevant illness, trauma or referrals for specialist advice or treatment, hospital admissions, consultations with your Dentist, GP or any other medical or dental advisor, therapist or counsellor.

We have asked your doctor/dentist not to reveal information about:

- Negative tests for HIV, Hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health or
- Predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from

The information you and your doctor/dentist provide about your health may result in us:

- Amend the level of benefit you are entitled to
- refusing to provide insurance in the future
- setting premiums at standard rates or increasing them about standard rates.

If you have any questions about your rights under the Act or relating to the process of us obtaining, assessing or storing medical information, please write to the Chief Underwriter at Compass Underwriting Ltd, 1-2 Crutched Friars, London EC3N 2HT.

I have read the details of my rights under the Access to Medical Records as explained above and in connection with my insurance claim. I hereby consent to Compass Underwriting seeking medical information from my doctor/dentist who has attended me concerning my teeth in connection with this claim and I agree that a copy of this consent shall have the validity of the original.

Certificate number

Your name

Date of birth

Your signature

Your Dentist/GP's name

Your Dentist/GP's address

Postcode

Your Dentist/GP's telephone number

Your Dentist/GP's facsimile number

I DO/DO NOT (delete as appropriate) WISH TO SEE THE REPORT BEFORE IT IS SENT TO COMPASS UNDERWRITING

4. Release of Medical Records (cont'd)

DATA PROTECTION ACT CONSENT FORM

You may wish for a family member or your legal representative to be given access to your personal, dental or medical information in order to help you with your claim.

In order for us to be able to discuss your claim with anyone other than yourself or our appointed agents we need your specific written permission. Please note that this consent would not allow anyone other than yourself to receive any benefit payments, unless we are paying your dentist direct.

You may sign (or revoke) this form at any stage throughout your claim.

Do you wish for your personal information to be given out to a family member or legal representative?

Yes

No

If **YES** then please complete the following form:

Your full name

Your address

Postcode

Your date of birth

The name of your appointed family member* or legal representative

(*Family member shall mean: husband, wife, civil partner, mother or father, son or daughter only).

Their relationship to you

Their contact address

Postcode

Their date of Birth

I hereby confirm that I **agree*/do not agree*** (delete as appropriate) in authorising the above representative, as named above, being given personal and medical information about me by Compass Underwriting Limited for as long as my claim shall last. This consent to be automatically terminated immediately upon completion of my claim.

Your signature

Date

