Accidental Dental Claim Form

This claim form consists of 3 parts and all sections must be completed in full.

Section A Your Statement This section is to be completed by the **Person Claiming** or such authorised person.

Section B Dentist Statement Your **Treating Dentist** must complete this section and we do not hold responsibility for any charges.

Section C Employer Statement This section must be completed by your **Employer**.

Important information

1. A claim cannot be assessed until we receive at a minimum, **all sections of the completed claim form**.
2. Incomplete questions may delay the assessment process and the claim form could be sent back to be completed.
3. To have a valid claim, you must provide **dental receipts**.
4. Please ensure you provide to us **proof of identification** e.g. copy of your driver's licence, proof of age card etc.
5. Please ensure you provide to us **proof of relationship** is you are not the member
6. All information provided must be legible.

Please return the completed Claim Form to n2n Claims Solutions

Email: info@n2nclaims.com.au

Post: Locked Bag 3111, Rhodes NSW 2138

If you have any questions, please don't hesitate to contact our claims department on **1800 999 626**

Section A – Your Statement

Member Details

Given name			**Surname**				
Address							
Suburb		**State**		**Postcode**			
Home phone		**Mobile**					
Fax		**Gender**		**Date of Birth**			
Email				**Height (cm)**		**Weight (kg)**	
Who are you claiming through?	☐ **Union** ☐ **Employer EBA**		**Name**				
Membership Number							
Marital Status	☐ **Never Married**	☐ **Divorced**	**Date**		☐ **Separated**	**Date**	
	☐ **Married**	☐ **De Facto**	**Date**				
At time of accident, were you employed?	☐ **Yes** ☐ **No**						

Dental Patient's Details

Given name		**Surname**			
Address					
Suburb		**State**		**Postcode**	
Home phone		**Mobile**			
Fax		**Gender**		**Date of Birth**	
Your relationship to Member	☐ **Spouse** ☐ **Child** ☐ **De Facto** ☐ **Other**				

Is the condition a result of an	☐ **Injury** ☐ **Sickness**
Description of Injury or Sickness	

If the condition is an Injury, please state exactly how, when and where it occurred. If applicable include any witness names and phone numbers.

When did symptoms first occur for the condition?	**Date**	**Time**	
In your opinion, do you believe the condition is work related?	☐ **Yes** ☐ **No**		
In your opinion, do you believe the condition is a result of playing sports?	☐ **Yes** ☐ **No**		
Had a similar condition in the past?	☐ **Yes** ☐ **No**	**Details**	

If "Yes", please complete the details below for the dentist attended.

DENTIST NAME	SURGERY/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED

Dentist Details (Please provide a history for over 5 years)

If attended **more than 2 dentists over the past 5 years**, please attach a list with the claim form.
Please note if a complete medical history is not provided, your claim may be delayed as we may require a full Medicare history.

Dentist name		**Surgery/Hospital**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax number**			
Email Address					
Date first ever attended		**Date last attended**		**Years attended**	
Dentist name		**Surgery/Hospital**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax number**			
Email Address					
Date first ever attended		**Date last attended**		**Years attended**	

Your Bank Details (Details are required in order to process any payments, if liability is accepted)

Name of financial institution			
Name on account (e.g. John Smith)			
BSB number		**Account No.**	

Other Benefit Details (If you have claimed through any of the below, please provide proof of your claim)

Were these services claimable through Medicare?		☐ **Yes** ☐ **No**	
Does the patient have Private Health Insurance?		☐ **Yes** ☐ **No**	
Were these services claimed through Private Health Insurance?		☐ **Yes** ☐ **No** ☐ **N/A**	
Fund Name		**Membership Number**	
Is the patient covered by another Dental Plan or entitled to a Healthcare Rebate?		☐ **Yes** ☐ **No**	
Insurer/Company name			
Type of claim			
Contact person		**Contact Number**	

Authorised Representative/s (This section is optional)

Complete this section if you **wish to authorise a family member or friend** to assist you with the claims process. It is required to allow us to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Name of authorised representative			
Representative's relationship to you		**Representative's date of birth**	
Representative's Phone Number		**Email**	

Declaration and Authorisation

Privacy Statement

In this statement "we", "us" and "our" means the Underwriter and n2n Claims Solutions Pty Ltd as its authorised representatives.

We are bound by the obligations of the Privacy Act 1988 (Cth) and the Australian Privacy Principles. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.n2nclaims.com.au or by calling us on 1800 999 626 and it sets out how:

- **we protect your personal information;**
- **you may access your personal information;**
- **you may correct your personal information held by us;**
- **you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.**

We, and our agents, need to collect, use and disclose your personal information in order to assess and manage any claim or obtain feedback on our group services. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to assess or manage a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- **you have the authority from them to do so and it is as if they provided it to us;**
- **you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the other parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.**

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting n2n Claims Solutions on 1800 999 626 or via email at info@n2nclaims.com.au.

By signing this form, you consent to us and the parties mentioned below collecting, using, and disclosing personal and sensitive information about you for the purposes described above of assessing and managing your claim or obtaining feedback on our group services.

1. **Parties may include: Any representative of n2n Claims Solutions, The Insured/Policy Owner, my Insurance Policy Broker, my Union/association, my authorised representatives, Employer(s) workers compensation insurer, insurance companies, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, accountant, financial advisor, and any physician, hospital, healthcare provider who has attended or examined me, in order for n2n Claims Solutions to be supplied with my full employment, financial and medical history including but not limited to tax returns, any medical or hospital records, reports, clinical notes and referral letters.**

2. **I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.**

3. **I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.**

4. **A photocopy, emailed or faxed version of this Declaration and Authority is considered as effective and valid as the original.**

Name (please print)			
Signature		**Date**	

Section B – Dentist's Statement **(Must be completed by your regular Treating Dentist)**

Please note any and all charges for the completion of this form is the full responsibility of the patient.
It may also be helpful with the assessment and ongoing management of this claim if you can supply any additional reports, clinical notes etc.

Patient's Details

Patient's name					
Patient's address					
Suburb		**State**		**Postcode**	
Gender		**Date of birth**		**Age**	

Are you the patient's regular Dentist?	☐ **Yes** ☐ **No**	**How long has this patient been attending your surgery/hospital?**	
The medical condition currently disabling the patient is an	☐ **Injury** **OR** ☐ **Sickness**		
When did the patient first attend your surgery as a result of this accident?	**Date**		
Please specify the date the accident occurred	**Date**		

In your opinion, please advise how & where the accident occurred

Has the patient had a similar condition in the past?	☐ **Yes** ☐ **No**	**If "Yes", please provide details below**	
Medical condition was		**Onset of the condition occurred**	

DENTIST'S NAME	**SURGERY/HOSPITAL NAME**	**CONTACT NUMBER**	**DATE ATTENDED**

In your opinion, do you believe the condition is work related?	☐ **Yes** ☐ **No**
In your opinion, do you believe the condition is a result of playing sports?	☐ **Yes** ☐ **No**
In regards to this accident, have you completed any other company forms?	☐ **Yes** ☐ **No**
If "Yes", please advise which company	

Please mark an 'X' on the universal numbering system of all damaged teeth, as a result of this accident.

Permanent Teeth

Upper Left							
16	15	14	13	12	11	10	9
17	18	19	20	21	22	23	24
Lower Left							

Upper Right							
8	7	6	5	4	3	2	1
25	26	27	28	29	30	31	32
Lower Right							

Primary Teeth

Upper Left				
J	I	H	G	F
K	L	M	N	O
Lower Left				

Upper Right				
E	D	C	B	A
P	Q	R	S	T
Lower Right				

Please complete in the table below for all dental services completed, as a result of the accident. (Please attach a copy of the receipts)

NUMBER/LETTER OF TOOTH	DATE OF SERVICE	DATE TOOTH 1ST DAMAGED	DESCRIPTION OF SERVICE	SERVICE FEE	OUT OF POCKET FEE

Were any of the above services required prior to the accident date?	☐ **Yes** ☐ **No**
If Yes, please advise the number/letter of the tooth/teeth	

Dentist's Declaration and Authority

I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Surgery/Hospital name					
Name (please print)					
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax number**			
Email					
Medical qualifications					
Signature		**Date**			

Section C – Employer's Statement **(Must be completed by your employer paymaster/manager only)**

Employee's Details

Employee's name		**Employee number**	
Employee's Occupation			
Employment type	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work		
Current work status	☐ Employed ☐ Resigned ☐ Terminated	**Date Ceased**	
Date commenced employment		**Date of accident occured**	
Does your company provide an EBA Income Protection policy?	☐ Yes ☐ No	**Insurer**	
Do you believe the employee's condition is work related?	☐ Yes ☐ No ☐ N/A		
Is your company self-insured for workers compensation?	☐ Yes ☐ No ☐ N/A		
Is the employee currently on workers compensation?	☐ Yes ☐ No ☐ N/A		
Does your company top-up workers compensation claims?	☐ Yes ☐ No ☐ N/A		
Name of Workers Compensation		**Policy No.**	

Employer's Declaration and Authority

I am authorised to complete this form on behalf of the employer and all information I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.

Company name					
Paymaster/Manager name		**Job title**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax No.**			
Email					
Signature		**Date**			