

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** if 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?	<input type="checkbox"/> Union	<input type="checkbox"/> Employer EBA	Name		
Membership Number					
Marital Status	<input type="checkbox"/> Never Married	<input type="checkbox"/> Divorced	Date	<input type="checkbox"/> Separated	Date
	<input type="checkbox"/> Married	<input type="checkbox"/> De Facto	Date		
At time of accident, were you employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Dental Patient's Details

Given name			Surname		
Address					
Suburb		State		Postcode	
Home phone		Mobile			
Fax		Gender		Date of Birth	
Your relationship to Member	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> De Facto	<input type="checkbox"/> Other	

Is the condition a result of an	<input type="checkbox"/> Injury <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In your opinion, do you believe the condition is a result of playing sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Had a similar condition in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have Private Health Insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were these services claimed through Private Health Insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Fund Name		Membership Number	
Is the patient covered by another Dental Plan or entitled to a Healthcare Rebate?		<input type="checkbox"/> Yes <input type="checkbox"/> 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. We may also use personal information, including de-identified or aggregated information where practicable, to analyse claims experience and improve our systems, processes and 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No		How long has this patient been attending your surgery/hospital?				
The medical condition currently disabling the patient is an				<input type="checkbox"/> Injury OR <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
In your opinion, do you believe the condition is a result of playing sports?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
In regards to this accident, have you completed any other company forms?				<input type="checkbox"/> Yes <input type="checkbox"/> 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								Upper Right							
16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Lower Left								Lower Right							

Primary Teeth

Upper Left					Upper Right				
J	I	H	G	F	E	D	C	B	A
K	L	M	N	O	P	Q	R	S	T
Lower Left					Lower Right				

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	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Casual	<input type="checkbox"/> Contractor	<input type="checkbox"/> Project Specific Work		
Current work status	<input type="checkbox"/> Employed	<input type="checkbox"/> Resigned	<input type="checkbox"/> Terminated	Date Ceased			
Date commenced employment				Date of accident occurred			
Does your company provide an EBA Income Protection policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insurer				
Do you believe the employee's condition is work related?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A				
Is your company self-insured for workers compensation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A				
Is the employee currently on workers compensation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A				
Does your company top-up workers compensation claims?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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		