Claim for hospital cash benefit

Denplan Dental Emergency and Injury Cover/Denplan Emergency – Benefit D

Denplan
Part of Simplyhealth

Before completing this form please read the terms and conditions in your policy document. To help us settle your claim quickly please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

Please ask your consultant or dentist to complete the information required concerning any treatment and advice that you've received.

Please be aware that dental records may be required to support your claim.

If you have any questions, please email trauma@simplyhealth.co.uk

Please send your completed form, within 60 days of the incident where reasonably possible, by email - trauma@simplyhealth.co.uk or by post - Denplan, part of Simplyhealth, Anton House, Chantry Street, Andover, SP10 1DE

Patient details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Registration number

Mr ◯ Mrs ◯ Miss ◯ Other

Date of birth D D M M Y Y Y Y

First name

Surname

House name or number

Address

Town/City

Postcode

Is this your permanent address? Yes ◯ No ◯

Home phone number

Mobile phone number

Email address*

*If you enter an email address on this form and you're the payer, it will be added to your account and email will become your preferred contact method. If you're not the payer, we'll use the email to contact you about your claim. Providing an email helps us communicate faster, improves security, and reduces our environmental impact. Please contact us if you'd like to discuss this further

Have you made any previous claims under this Denplan Dental Emergency and Injury Cover/Denplan Emergency policy? Yes ◯ No ◯

Hospital and treatment details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Date of admission D D M M Y Y Y Y Time : AM ◯ PM ◯ Date of treatment D D M M Y Y Y Y

Date of discharge D D M M Y Y Y Y Time : AM ◯ PM ◯

If your stay exceeded 5 days, please provide a copy of your admittance and discharge form or any other supporting evidence

Please provide the name and address of the hospital where you were treated

Postcode

Name of consultant

Specialism

Please give a description of treatment/consultation given

Please turn over

Payment details

Dentist or patient to complete. Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully. We may return the claim form to you if this not completed.

◯ Direct payment into the bank account we debit your monthly subscription from

Or

◯ Cheque payable to

Patient's declaration

To be completed by the patient (or parent/guardian of a patient under 16 years)

I confirm that I am the patient (patient's parent or guardian if under 16 years of age) and I declare that all the information provided on this form is true and complete. I hereby authorise any dentist or person who has examined me/the patient to provide Denplan Limited, or its representatives, with any information concerning the above matters to support this claim. I understand that Denplan Limited, on behalf of the Insurers, reserves the right to appoint an examiner or make such other enquiries as it considers appropriate before agreeing any claim.

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date D D M M Y Y Y Y

Dentist's/Consultant's declaration

I confirm that the information I have given in respect of hospital admission and nature of treatment are correct.

Dentist's/Consultant's name

Dentist's/Consultant's signature

Date D D M M Y Y Y Y

GMC / GDC number

Contact phone number (in case of subsequent enquiry)

Any costs incurred when obtaining the above signature and medical records are not covered under the terms of the Supplementary Insurance.