Claim for mouth cancer cover and Hospital Cash Benefit

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

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 treating 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)

Patient 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

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

Diagnosis and treatment section

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

Please provide the name and address of the hospital where the diagnosis and / or treatment took place

Hospital name

Hospital address

Postcode

Where is the primary site of the cancer?

On what date did the patient first became aware of the symptoms? D D M M Y Y Y Y

Please describe the treatment provided

What was the date of diagnosis? D D M M Y Y Y Y

Does the treatment relate to tests or consultations for non-invasive tumours? Yes ○ No ○

Please describe any further treatment that may be planned

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 the information provided on this form is true and complete. I hereby consent to and authorise the General Practitioner and/or any Specialist involved in my/the patient's care to discuss treatment details and discharge arrangements with Denplan Limited. 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.

I declare that the mouth cancer was not:

- diagnosed before I joined Denplan
- diagnosed within 90 days of joining Denplan or having investigations or waiting for the outcome of tests within those 90 days, even if the diagnosis is not made until later
- caused as a result of chewing tobacco products, betel nut or prolonged alcohol abuse
- found in the tonsils

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date D D M M Y Y Y Y

Dentist's/Consultant's declaration

I declare that I am the patient's Specialist (or General Practitioner), that the patient was referred to me by his/her General Practitioner, and that the information given is, to the best of my knowledge, true and correct.

Name

Signature

Date D D M M Y Y Y Y

Title

Are you a Consultant Maxillofacial Surgeon? Yes ○ No ○

If 'No' please give details of your medical specialism