The Dental Insurance Partnership Ltd
Wentworth, 9 Woodlands
Off Roundwood Road
Baildon
West Yorkshire
BD17 6SP

M: 07940-560281
E: griggs.dip@talk21.com

Notes: Please read the following instructions before completing the claim form.

Before undertaking any treatment under this policy please check the policy Terms and Conditions (and endorsements) for details of the cover provided.

It is important that the patient and the dentist complete this form fully.

As soon as treatment becomes necessary, you must complete this form and return it to us with all the following documentation, if any supporting documentation is missing this will result in us being unable to process the claim. If you are unable to provide any of the documentation requested this may result in us being unable to accept the claim.

Type of claim (please tick as appropriate)

Failure to Integrate ☐

Accidental Damage (Extra Oral Only) ☐ Emergency Treatment ☐

Please use the tick boxes to indicate which supporting evidence is attached.

- Patient has a Hygiene Program in place. ☐
- Evidence of original work carried out including operation notes and A copy of the original treatment invoice. ☐
- Details of the proposed remedial treatment plan with associated costs ☐
- An invoice of the amount claimed in respect of remedial treatment costs ☐
- X-rays of implants pre-op, within 6 months of placement ☐
- X-rays of implants post restoration showing primary stability if claim is being made after exposure of implant has taken place ☐
- X-rays of implants or photographic evidence of failure (failure only) ☐
- X-rays of implant area/damage after accident has occurred but before remedial treatment is carried out (accident only) ☐

TRAUMA

- Statement by dentist carrying out emergency/accident treatment describing the treatment given (Accident and Emergency only) ☐
- If accident/emergency occurred overseas evidence of time spent overseas e.g. copy of flight schedule (Accident and emergency only) ☐

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To be completed by Patient

1. Patient Details (please complete in block capitals)

Policy Number: Title: Mr/Mrs/Ms/Miss/Other

First Name: Surname:

Address:

County: Postcode:

2. Are you covered by any other insurance? Yes ☐ No ☐

Details of the other insurer including policy number:

3. For a claim in respect of Accidental Damage or Emergency Treatment please give details of the accident/emergency including where, when and how it happened

Date of accident: Time of Accident:

Full Description of Accident:

Was the accident reported to any authorities e.g. Police? Yes ☐ No ☐

If yes please give full details:

Authority's reference number:

4. Claim Details (Claims will be settled directly with the dentist except in the case of emergency treatment)

Total amount claimed: £

5. Patient Declaration

I declared to the best of my knowledge and belief that the information given on this form is true and complete

Signature: Date:

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To be completed by Dentist

1. Treating dentist details (stamp if available) **Other dentist if involved**

2. This section must be completed before the claim will be considered. - Please provide the following :

- **Failure to integrate**
  - **a) Date of Failure first identified**_____
  - **b) Reason/Explanation for why the implant failed-**

    _____

    _____
- **Trauma**
  - **When the accident occurred**_____
  - **Circumstances of Accident/Trauma**_____
- **Emergency**
  - **When emergency occurred**_____
  - **Circumstances of emergency.**_____

3 Implant details

Implant Manufacturer: Tooth number(s) of implant(s) affected by failure/accident/emergency:

_____

4. Please provide full details of Remedial Treatment including dates and cost breakdown.

Payment will only be made for work completed.

Date	Remedial treatment given/to be given	Cost
	Value of implants replaced under Manufacturer's warranty	**(£)**
	Total Amount Claimed	

5. Dentist Declaration

I declare to the best of my knowledge that the information supplied on this form is true and complete and that the treatment was a direct result of an accident caused by Extra-Oral Impact to the patient's dentition and/or supporting structure, dental emergency or due to failure to integrate.

Signature: Date: