CLAIM FORM

New Zealand Dental Claim Form

EXTF196

For NON dental claims, please use the Protect Injury & Sickness claim form.

Call ATC for Assistance Toll Free on 0800 300 143

1. **You** complete Section A.

2. Your **Dentist** completes Section B.

3. Check all questions have been answered (including by selecting either 'Yes' or 'No' wherever this option is given) and each Section has been signed and dated.
   Your claim will be delayed if we have to return your claim form to you because it is incomplete.

4. Send, or scan and email, or deliver your completed form in person to:
   Post: ATC Insurance Solutions Pty Ltd
   Level 4, 451 Little Bourke Street, Melbourne Vic 3000
   Email: claims@atcis.com.au

ATC Insurance Solutions Pty Ltd (ABN 25 121 360 978 AFSL 305802) is acting under the authority of the underwriters and will handle this claim as agent of the underwriters and not the claimant.

SECTION A ➲ Claimant's Statement

All questions to be completed in full by the claimant.

Protect number (if known) ____

Union member Yes ◯ No ◯ Union name____________________ Membership no.____________________

Surname______________________________ Given names______________________________

Sex Male ◯ Female ◯ Other ◯ Date of birth ____/____/________

Street address____

Suburb______________________ City______________________ Postcode__________

Contact telephone____________________ Email______________________________

Name of employer____

Postal address (If different from above)

Street address____

Suburb______________________ City______________________ Postcode__________

Electronic Funds Transfer

Please provide your banking details so any claim benefits can be transferred directly in to your account.

Bank name________________________ Bank branch________________________

Account name________________________ Account no. ________________________

Injury Statement

1. Date of injury____/____/________ Time of injury____________ am____ pm____

   Date of first dental treatment ____/____/________

2. If not yourself, please provide the name of the individual who suffered the dental injury and your relationship to them:

   ____

3. Identify the accidental dental injury and note how many teeth / fillings were damaged / lost (e.g. 2 Loss of teeth):

   _____Loss of filling _____Loss of teeth _____Chipping of teeth

   _____Fractured or broken tooth _____Damaged denture / dental plate

4. Describe the accident that caused your dental injury______________________________

   ____

   ____

5. Where did the accident occur?______________________________

   ____

6. Were there any witnesses to the dental accident? Yes ◯ No ◯

   If Yes, provide witness name/s and contact number/s______________________________

   ____

7. Did the dental accident occur at work, including during a meal-break or authorised recess? Yes ◯ No ◯

ATC Insurance Solutions Pty Ltd Telephone 0800 300 143 (Toll Free) Email claims@atcis.com.au Web www.atcis.com.au

Privacy

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 2020.* This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. 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 provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Accident Compensation Corporation will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

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 third 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 and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC Toll Free on 0800 300 143 or write to us at the address given on page one.

Optional Authority

The following authority is optional and should only be completed if you wish or require another person to act on your behalf in relation to this claim. Generally, such an authority should only be provided when the claimant is incapacitated, not an adult, or other difficulties prevent you from acting effectively on your own behalf with regard to this claim.

Complete if applicable. I hereby authorise the person named below to act on my behalf in relation to this claim and authorise ATC to discuss and share any relevant information.

Name of person acting on your behalf ____________________

Relationship to claimant ____________________

Telephone ____________________ Email ____________________

Street address ____________________

Suburb____________________ City____________________ Postcode____________________

Signature (of claimant, if appropriate)____________________

Authority and Declaration

I hereby authorise any hospital, physician, insurer, Accident Compensation Corporation, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Accident Compensation Corporation claims, claims with any other insurer, or any leave benefits and payments, to be released to ATC. I agree that a photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

I declare that:

my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.

Name (print) ____________________

Signature ____________________ Date ____/____/________

Important notice: You must tell us if you return to work or become medically fit to do so. If you fail to tell us and continue to receive benefits under the policy you could be prosecuted for fraud. You might also lose all of your rights under the policy for this claim and any future claims.

SECTION B ➲ Dentist's Statement

All questions in Section B to be completed in full by the Dentist.

Claimant's full name____

Sex Male ◯ Female ◯ Other ◯ Date of birth _____/_____/_________

1. Describe the nature of the dental damage suffered by the claimant and the number of teeth damaged:

Loss of filling ____

Loss of teeth ____

Chipping of teeth____

Fractured or broken tooth ____

Damaged denture / dental plate____

Other____

2. Advise the treatment and ADA item numbers that relate to this dental injury (please also state the FDI two-digit tooth identification number/s)

____

____

3. On what date did the claimant first consult you for the dental damage? _____/_____/_________

4. Was the dental damage referred to in question 1 caused solely and directly by a sudden, unexpected, and specific event that has occurred independently of any other cause? Yes ◯ No ◯

If Yes Date of event _____/_____/_________ Time of Event____________________

Describe the event that resulted in the dental damage__________________________________

____

____

If No Please list the cause/s ____

____

5. Did the claimant report that the dental damage occurred at work, including during a meal-break or authorised recess?

Yes ◯ No ◯

I hereby certify that I am a registered dentist and that I have personally examined the above-named claimant.

Name____

Qualification_________________________________ Provider no.___________________________

Telephone____________________________ Fax ______________________________

Email____

Address ____

Suburb ____

City___________________________________Postcode___________________

Signature ____

Date_____/_____/_________

AFFIX STAMP HERE

ATC Insurance Solutions Pty Ltd Telephone 0800 300 143 (Toll Free) Email claims@atcis.com.au Web www.atcis.com.au