CLAIM FORM

Accidental Dental Injury

EXTF046

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

Call ATC for assistance on 1800 994 694

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 fax, 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
   Fax: (03) 9867 5540
   Email: info@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_____ State_____ Postcode_____

Contact telephone_____ Email_____

Name of employer_____

Postal address (If different from above)

Street address_____

Suburb_____ State_____ 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_____BSB _____–_____ 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 ◯

Privacy, Authority and Declaration ➲ SECTION A Continued

Privacy Act

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 1988* (Cth), the Privacy Amendment *(Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. 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 Medicare Australia and Centrelink 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 on (03) 9258 1700 or write to us at the address given on page 1.

Authority

I hereby authorise any hospital, physician, insurer, Medicare Australia, 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 Workers' Compensation claims, claims with any other insurer or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

Complete if applicable.

Name_____ Date of birth_____/_____/_____ Relationship_____

Telephone number _____ Email_____

Declaration

I declare that:

a. the claim I am making for injury or sickness IS NOT WORK-RELATED and if my injury or sickness is work-related, I have disclosed this clearly in my answers in this section, and

b. 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.

Signature _____

Name (print) _____ Date _____/_____/_____

ATC Insurance Solutions Pty Ltd Telephone 1800 994 694 (ATC Claims) Fax 03 9867 5540 Email info@atcis.com.au Web www.atcis.com.au

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_____State_____ Postcode_____

Signature _____

Date_____/_____/_____

AFFIX STAMP HERE

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