

PUPIL & STAFF PERSONAL ACCIDENT INSURANCE SCHEME

DENTAL ACCIDENT AND EMERGENCY REPORT FORM

Please complete and return this claim form by email or post to: schemes.claims@marsh.com or Marsh Ltd, Education Practice, Capital House, 1-5 Perrymount Road, Haywards Heath, West Sussex RH16 3SY. Forms should be received within 30 days (or 60 days in the case of emergency treatment received outside the UK) of the incident from which the claim arose.

Please note: insurers will pay reasonable fees up to a total overall maximum of £2,000 for emergency treatment and £10,000 for dental injury. Please see policy wording for terms and conditions.

Please complete sections A, B (if applicable), D1 and E, while Sections C and D2 should be completed by the treating dentist.

SECTION A

Please complete in **BLOCK LETTERS**

Pupil / Staff Member's Details

Title:	_____
Forename(s)	_____
Surname:	_____
Date of birth:	_____
Name and address of school:	_____
Post code:	_____
Contact name and address:	_____
Post code:	_____
Relationship to claimant if under 18: (e.g. parent/ guardian/ school acting in loco parentis)	_____
Telephone number:	_____
Mobile telephone:	_____
Email address:	_____

Are you covered by, or claiming under any other insurance in relation to this emergency? Yes No

If 'Yes', please give details:

Your Registered Dentist's Details

Title: _____
Forename(s) _____
Surname: _____
Practice name: _____
Address: _____
Post code: _____
Telephone: _____
Email: _____

Your Treating Dentist/Consultant's Details (If Different From Your Registered Dentist)

Title: _____
Forename(s) _____
Surname: _____
Practice name
and address: _____
Post code: _____
Telephone: _____
Email: _____

SECTION B

Please complete in BLOCK LETTERS

Emergency Treatment – If Not Applicable Please go to SECTION D

Date and time of the emergency
treatment or consultation: _____
Please give details of nature of
the dental emergency: _____
If you were abroad: Date of
leaving UK _____
Date of returning: _____

You may claim emergency treatment costs if away from home. Please provide details of the treatment in Section C, (if you have a receipt for emergency treatment overseas/away from home, a dentist's signature is not required).

Did the dentist have to open their surgery to treat you? Yes No
Was a call out fee incurred? Yes No
If "Yes", please state the amount of the call out fee: £

SECTION C – For completion by the dentist

Please complete in BLOCK LETTERS

Please give details of the emergency treatment carried out and itemise all chargeable aspects

Tooth	Details	COST (£)
Total		

Dentist Declaration

Are you the patient's registered dentist? Yes No If "No" are you on the emergency rota? Yes No

Signature:

Date:

Name (please print)

SECTION D1 – Dental Injury – If not applicable please go to the patient's declaration.

Please state how the dental injury occurred:

Nature of the injury:

Where did the accident happen?

Date of accident:

SECTION D2 – Treatment Information

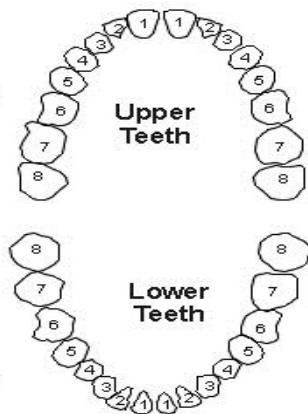
For completion by the dentist

Date treatment started:

Date treatment completed:

Please give details of any pre-existing conditions:

Please indicate the teeth injured on the diagram below and describe the injury/injuries sustained to the relevant teeth and any percentage of the tooth lost.



Tooth (e.g. UL1)	Details of Treatment Given	COST (£)
Total		

If ongoing treatment is required, please give details of planned treatment and expected costs below:

Tooth (e.g. UL1)	Details of Treatment Given	COST (£)
Total		

I have enclosed relevant x-rays and/or photographs: Yes No

Patient's Declaration — All Patients Must Sign if Claiming Expenses

If the patient is under 18 years then the declaration must be completed by the parent/guardian.

I warrant the truth of the information given enclosed. I understand that the issue of this form is not an admission of my claim. I am also aware that insurers may wish to make enquiries, in which respect I consent to any dental or medical practitioner or other person in possession of information relevant to my claim to disclose that information to insurers without reference to me. I consent to insurers contacting me. I acknowledge that insurers may invite me to undergo examination by a dentist or doctor, or have my dental medical records reviewed by a dental advisor, and that if I decline it may refuse my claim.

Signature:

(Parent/guardian if claimant under 18)

Name:

Date:

Section E — Payment Information

Please enclose receipts if you have already paid the dentist's account (Emergency & Treatment Costs Only)

Payment should be made to (please tick as appropriate): patient/parent treating dentist/consultant

Payment by BACS

Account name:

Sort code:

Bank account number:

To be Completed by The School

(Confirmation that the pupil in question was on cover at the time of the accident)

Name of school:

Name of pupil:

Name of school official:

Signature of school official:

Date:

YOUR INFORMATION

To administer the scheme, we need to collect and use personal data about you, such as your name and contact details, which may include special categories of personal data (e.g. about your health). The purposes for which we use personal data may include arranging insurance cover, claims and for crime prevention. More information about our use of personal data is provided in the Marsh Privacy Notice at www.marsh.co.uk/privacy or in hard copy on request by emailing or writing to the Data Protection Officer, Marsh Ltd, Tower Place, London EC3R 5BU or dataprotection@marsh.com.

In administering the scheme, we may share personal data you provide with third parties such as insurers, reinsurers, loss adjusters, subcontractors, our affiliates and to certain regulatory bodies who may require your information themselves for the purposes described in the Marsh Privacy Notice.

Depending on the circumstances, our use of personal data may involve a transfer of data to countries outside the UK and the European Economic Area that have less robust data protection laws. Any such transfer will be done with appropriate safeguards in place.

In completing the form, you are providing health information which falls within a special category of personal data. Your consent to our (and other insurance market participants') use of special categories of personal data (e.g. health information) is necessary for us to administer the scheme. Although you may withdraw your consent at any time, if you do we may be unable to continue to provide services in relation to the scheme and this may mean that we are unable to process your enquiry or claim or your insurance cover will stop.

Where you are providing us with information about a person other than yourself (including any children over the age of 13), you agree to notify them of our use of their personal data and obtain their consent to our use of any special categories of personal data such as health information. You agree that participation in the scheme is conditional on you providing such notices and obtaining such consents. Any third party whose personal data we use may withdraw any such consent at any time but if consent is withdrawn then we may be unable to continue to provide services in relation to the scheme to them (and possibly you), and this may mean that we are unable to process enquiries or claims or that the relevant insurance cover will stop.

By signing and returning this form, you consent to our processing your sensitive personal data for the above purposes.

Signed:

Name:

Relationship to claimant:

Date:



Chartered

The information contained herein is based on sources we believe reliable and should be understood to be general risk management and insurance information only. The information is not intended to be taken as advice with respect to any individual situation and cannot be relied upon as such.

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