ATC
INSURANCE SOLUTIONS

Protect

CLAIM FORM

# *Protect* 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 ◯ Date of birth _____/_____/_________

Street address____________________________________________________________

Suburb________________________________________ State______________ Postcode______________

Postal address (If different from above)

Street address____________________________________________________________

Suburb________________________________________ State______________ Postcode______________

Contact telephone______________________________ Email______________________________

Name of employer____________________________________________________________

**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 ◯


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

## 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.**

Signed ____________________________________________________________

Name (print) ______________________________________________ Date: ____/____/________



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# SECTION B ➲ Dentist's Statement

Claimant's full name___________________________________________

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

**1.** Did the claimant suffer an injury? Yes ◯ No ◯

**2a.** Date of injury_____/_____/_________ **2b.** Time of injury_____________ am_____ pm_____

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

**4.** Describe the incident that resulted in the injury ___________________________________________

___________________________________________

___________________________________________

___________________________________________

___________________________________________

**5.** Describe the nature of the dental damage suffered by the claimant (eg. fractured or broken tooth, loss of tooth, chipped tooth) and the number of teeth damaged ___________________________________________

___________________________________________

___________________________________________

___________________________________________

___________________________________________

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

___________________________________________

**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_____________

Signed _________________________ Date_____/_____/_________

AFFIX STAMP HERE



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