Denplan Corporate Claim Form

PLEASE FILL IN ALL DETAILS AND USE BLOCK CAPITALS THROUGHOUT.

Please follow these instructions carefully to ensure that your claim will be processed efficiently and without any need for further clarification.

1. Do not forget to attach original receipts and sign and date this form
2. If this is your first claim, please attach a copy of your dental records for assessment. Alternatively we can request a copy from your dentist which will delay assessment of your claim.
3. We recommend that you photocopy the completed form and any attachments for your records.
4. Send this form within TWO MONTHS of treatment to Atlas Healthcare Insurance Agency Limited – Abate Rigord Street, Ta' Xbiex XBX1121, Malta.

Subscriber's Details

Policy No: Group Name:

Title: First Name: Surname: Id. Card No:

Address:

Patient and Claim Details – *To be completed whether patient is the subscriber or not*

Title: First Name: Surname: Id. Card No:

Tel No: Mobile No: Email address:

Is this the first claim for this condition? Yes No Date Person first aware of symptoms: D D M M Y Y Y Y

Is this claim claimable from any other source? Yes No If YES give details

If you are submitting a claim for a dental injury, please complete the additional information below.

Was the dental injury sustained while participating in a sporting activity? Yes No

If YES please give details of the sporting activity

Please give details of the injury

Payment Details

Request for payment to be made to a person other than the patient aged 18 or over.

To be completed ONLY if payment is to be made to a person other than the patient aged 18 years or over.

I authorise benefit to be paid directly to:

Address:

Patient's signature if aged 18 or over
(Subscriber's signature if patient is under 18): Date: D D M M Y Y Y Y

Request for payment to be credited directly to a Malta bank account.

☐ I request benefit to be paid directly to: bank branch

Bank account number: In the name of:

I understand that future claim payments in respect of this patient will be credited to this account unless otherwise specified.

Please send notification of payment to the following email address:

☐ Please reverse my previous instructions to credit a bank account for claims in respect of this patient and issue cheques for this and any future claim payments.

Patient's signature if aged 18 or over
(Subscriber's signature if patient is under 18): Date: D D M M Y Y Y Y

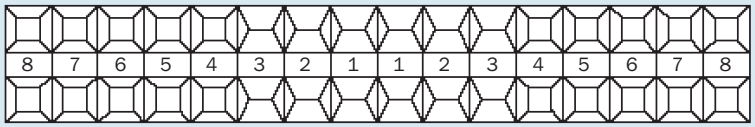
Declaration

I declare that to the best of my knowledge and belief the statements made on this form are true and complete.
Data Protection Notice – AXA PPP healthcare implements strict controls over electronic and manual personal data. Please read this declaration before signing the claim form to understand how your data may be processed.
I consent to the processing of my personal data by the Company or any other members of the Group supplied by myself as long as this processing relates to my dental insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and the keeping of statistics.
I authorize the company to seek any medical information relating to myself or my dependents. I also authorize any dentist or doctor, hospital, laboratory or other insurance provider to provide full medical information concerning myself or my dependents. I understand that the company may, in addition, exchange information with others (including the Malta Insurance Association or other insurance companies) for the prevention of fraud.
I authorize the Company to keep me informed of its products and services by mail, fax or email or other electronic means. I understand that I may inform them in writing if I do not wish to receive this information. I also understand that I have the right to request access to my personal data by contacting Atlas Healthcare Insurance Agency Limited in writing.

Patient's signature if aged 18 or over
(Subscriber's signature if patient is under 18): Date: D D M M Y Y Y Y

Medical Statement – *To be completed by your Dentist*

Please complete if this is your patient's first claim
Has patient consulted you within the last twenty four (24) months? Yes ☐ No ☐
If 'yes' please specify date of last visit and details (eg fillings, root canal treatment etc) of recommended treatment, if any:



Date of first consultation for this condition: D D M M Y Y Y Y

Date patient first aware of symptoms: D D M M Y Y Y Y

Dental history of this condition including details of previous treatment. If more than one visit is necessary kindly provide us with a treatment plan

Please tick to indicate the type of treatment received.

	Routine & Restorative	Injury or emergency	Number of units	Total Charge
Routine treatment				
Examination				
Scale and polish				
Bite-wing x-ray				
Medium x-ray				
Large (panoral) x-ray				
Fillings				
One surface amalgam filling				
Two or more surface amalgam filling				
One surface composite anterior filling				
Two or more surface composite anterior filling				
One surface composite posterior filling				
Two or more surface composite posterior filling				
Root Canal Treatment				
Root canal treatment – incisor / canine				
Root canal treatment – premolar				
Root canal treatment – molar				
Crowns				
Porcelain jacket crown				
Metal bonded crown				
Dentine bonded crown				
Full gold crown				
Zirconia crown				
Post				

	Routine & Restorative	Injury or emergency	Number of units	Total Charge
Bridgework				
Metal bonded porcelain bridgework				
Adhesive bridge				
Inlay				
Onlay/veneer				
Zirconia bridge				
Dentures				
Permanent acrylic				
Permanent metal				
Sundry				
Simple extraction				
Surgical extraction				
Periodontal treatment				
Other routine, restorative, injury or emergency treatment				
Give details				

Total claims value	€

Mouth cancer treatment – please contact us for details required in this case.

Dentist's Name: Dentist's Reg. No:

Practice Name: Practice Tel No:

Dentist's signature: Date: D D M M Y Y Y Y

Atlas Healthcare

Atlas Healthcare Insurance Agency Limited
Abate Rigord Street Ta' Xbiex XBX 1121
Tel 21 322 600 Fax 23 265 601
47-48 Ta' Xbiex Sea Front Ta' Xbiex XBX 1021
Tel (356) 23 435363 Fax (356) 21 344666
Email health@atlas.com.mt Website www.atlas.com.mt/denplan
Calls may be recorded for security and training purposes.

AXA PPP healthcare

AXA PPP healthcare limited.
Registered office 5 Old Broad Street, London, EC2N 1AD.
Registered number 3148119 England.
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