WINDSOR INCOME PROTECTION

# QUEENSLAND UNITED VOICE ACCIDENTAL DENTAL CLAIM FORM

**This claim form consists of 3 parts and all sections must be completed in full.**

**Section A Claimant Statement** – The claimant is to complete all questions in this section.
**Section B Dentist Statement** – The treating dentist must complete Section B after completing Section A and we do not hold any responsibility for any charges.
**Section C Employer Statement** –Must be completed by the United Voice member's employer.

**Important information**

1. A claim cannot be assessed until we receive all sections of the original completed claim form.
2. To have a valid claim you must provide original or certified copies of the dental receipts, proof of identification and relationship to the patient.
3. Incomplete questions may delay the assessment process and the claim form could be sent back to be completed.

Please forward the completed claim form to:

**Attention: Claims Department**
**Windsor Income Protection**
**PO Box 3651**
**Rhodes NSW 2138**

If you have any questions, please don't hesitate to contact our claims department on **1300 547 966**

## Section A – Claimant Statement

### United Voice Member's Details

| | | | | | |
|---|---|---|---|---|---|
| **Given name** | | **Surname** | | **Title** | |
| **Address** | | | | | |
| **Suburb** | | **State** | | **Postcode** | |
| **Home phone** | | **Mobile** | | | |
| **Fax** | | **Gender** | ☐ M ☐ F | **Date of Birth** | / / |
| **Email** | | | | | |
| **Marital Status** | ☐ Never Married | ☐ Divorced / / | | ☐ Separated / / | |
| | ☐ Married / / | ☐ De Facto, please advise period lived together _____Years _____Months | | | |
| **Member No.** | **(If uncertain of your member number, please call United Voice on 1800 065 885)** | | | | |
| **At the time of the accident, were you employed** | ☐ Yes ☐ No | | | | |

### Bank Details

| | | | |
|---|---|---|---|
| **Name of financial institution** | | | |
| **Name on account** | | | |
| **BSB number** | | **Account No.** | |

### Dental Patient's Details

| | | | | | |
|---|---|---|---|---|---|
| **Given name** | | **Surname** | | **Title** | |
| **Address** | | | | | |
| **Suburb** | | **State** | | **Postcode** | |
| **Home phone** | | **Mobile** | | | |
| **Gender** | ☐ Male OR ☐ Female | | | **Date of Birth** | / / |

| | |
|---|---|
| Patient's relationship to Member | ☐ Spouse ☐ Child ☐ De Facto ☐ Other, please specify_____ |
| Is the patient's condition a result of an | ☐ Injury OR ☐ Sickness |
| Description of Injury or Sickness | |
| | |
| Please specify exactly where and how the accident occurred | |
| | |
| | |
| When did symptoms first occur for your patient's condition? | Date: / / Time: : |
| In your opinion, do you believe the patient's condition is work related? | ☐ Yes ☐ No |
| Has the patient had a similar condition in the past? | ☐ Yes ☐ No |

If Yes, please complete the details below for the dentist/physician attended.

| DENTIST/DOCTOR'S NAME | PRACTICE/SURGERY NAME | CONTACT NUMBER | DATE ATTENDED |
|---|---|---|---|
| | | | / / |

## Other Benefit Details

| | |
|---|---|
| Is the patient covered by another dental plan or entitled to a healthcare rebate? | ☐ Yes ☐ No |

If Yes, please complete the below and provide details of the claim. For example an acceptance letter, copies of any benefits and receipts.

| | | | |
|---|---|---|---|
| Insurer/Company name | | | |
| Contact person | | Contact No. | |

## Authorised Representative's (this section is optional)

Complete this section if you wish to authorise a family member or friend to assist you with the claims process, as it is required to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

| | | | |
|---|---|---|---|
| Name of authorised representative | | | |
| Representative's relationship to you | | Representative's date of birth | / / |

## Declaration & Authorisation

**Privacy Statement**

**In this statement "we", "us" and "our" means Lloyd's and Windsor Income Protection as its agent.**

**We are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.**

**Our Privacy Policy, available at www.windsorip.com.au or by calling us, sets out how:**

- **we protect your personal information;**
- **you may access your personal information;**
- **you may correct your personal information held by us;**
- **you may complain about a breach of the Privacy Principles or Registered Privacy Code and how we will deal with such a complaint.**

**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 who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.**

**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 if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting Windsor Income Protection on 1300 547 966 or via email at info@windsorip.com.au.**

1. **I hereby declare that I am the Legal Owner of this policy and authorise Windsor Income Protection to disclose the personal information to any of the following parties: any authorised representative of Windsor Income Protection, United Voice and any physician, hospital, healthcare provider and dentist who has attended or examined the patient.**
2. **I hereby authorise and consent to Windsor Income Protection to collect any information for the assessment of my claim from any of the following: United Voice, employer, workers compensation insurer, insurance company, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, dentist, physician, hospital, healthcare provider who has attended or examined the patient in order for Windsor Income Protection to be able to be supplied with my full medical history including but not limited to any medical or hospital records, reports, clinical notes and referral letters.**
3. **I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.**
4. **I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.**
5. **A photocopy, emailed and fax copy of this authority is considered as effective and valid as the original.**

| | | | |
|---|---|---|---|
| **Name (please print)** | | | |
| **Signature** | | **Date** | / / |

## Prior to sending us your claim, please ensure the following document are attached

- ☐ Proof of identification for the patient, such as drivers licence, passport etc.
- ☐ Original or certified copy of the receipts for the dentist service.
- ☐ Proof of relationship for example certified copy of the marriage certificate, birth certificate etc.
- ☐ Details of other dental benefits/rebates (if applicable).

## Section B – Dentist's Statement (must be completed by your treating dentist)

*Please note any and all charges for the completion of this form, is the full responsibility of the patient.

### Patient's Details

| | | | | | |
|---|---|---|---|---|---|
| Patient's given name | | Surname | | | |
| Patient's address | | | | | |
| Suburb | | State | | Postcode | |
| Gender | ☐ Male ☐ Female | Date of birth | / / | Age | |

| | |
|---|---|
| Are you the patient's regular dentist? | ☐ Yes ☐ No |
| How long has this patient been attending your surgery? | Years Months |
| Was the cause of the patient's dental service was as a result of an | ☐ Injury OR ☐ Sickness |
| When did the patient first attend your surgery as a result of this accident? | / / |
| Please specify the date the accident occurred | / / |
| In your opinion, please advise how & where the accident occurred | |
| | |
| Has the patient had a similar condition in the past? | ☐ Yes ☐ No |

If Yes, please give details below of the similar condition, time of onset and contact details of the dentist and surgery attended for that condition.

Medical condition was….  Onset of the condition occurred in….

| DENTIST'S NAME | SURGERY'S NAME | CONTACT NUMBER | DATE ATTENDED |
|---|---|---|---|
| | | | / / |

| | |
|---|---|
| In your opinion, do you believe this condition is work related? | ☐ Yes ☐ No |
| In your opinion, do you believe this condition is sports related? | ☐ Yes ☐ No |
| In regards to this accident, have you completed any other company forms? | ☐ Yes ☐ No |
| If Yes, please advise to which company. | |

**Please mark an 'X' on the universal numbering system of all damaged teeth, as a result of this accident.**

### Permanent Teeth

| Upper Left | | | | | | | |
|---|---|---|---|---|---|---|---|
| 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| Lower Left | | | | | | | |

| Upper Right | | | | | | | |
|---|---|---|---|---|---|---|---|
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 |
| Lower Right | | | | | | | |

### Primary Teeth

| Upper Left | | | | |
|---|---|---|---|---|
| J | I | H | G | F |
| K | L | M | N | O |
| Lower Left | | | | |

| Upper Right | | | | |
|---|---|---|---|---|
| E | D | C | B | A |
| P | Q | R | S | T |
| Lower Right | | | | |

Please complete in the table below for all dental services completed, as a result of the accident. (Please attach a copy of the receipts)

| Number/ Letter of tooth | Date of service | Date tooth 1st damaged | Description of service | Service fee |
|---|---|---|---|---|
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |
| | / / | / / | | $ |

| | |
|---|---|
| Were any of the above services required prior to the accident date? | ☐ Yes ☐ No |
| If Yes, please advise the number/letter of the tooth(s) | |

## Dentist's Declaration and Authority

I hereby certify that I am a registered dentist and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that Windsor Income Protection may provide copies of these forms to any required representative and or third parties deemed necessary to assist the ongoing assessment of the claim.

| | | | | | |
|---|---|---|---|---|---|
| Name of Surgery | | | | | |
| Dentist name | | | | | |
| Address | | | | | |
| Suburb | | State | | Postcode | |
| Phone number | | Fax number | | | |
| Email | | | | | |
| Qualifications | | | | | |
| Signature | | Date | / / | | |

## Section C – Employer's Statement

### Employee's Details

| | | | |
|---|---|---|---|
| Employee's name | | Employee's number | |
| Employee's occupation | | | |
| Employment type | ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Self-Employed | | |
| Current work status | ☐ Employed | ☐ Resigned / / | ☐ Terminated / / |
| Date commenced employment | / / | Date accident occurred | / / |
| Is the employee covered under an Employer Enterprise Agreement Income Protection policy? | | | ☐ Yes ☐ No |
| If Yes, please advise the insurance company's name | | | |
| Do you believe the claiming condition is work related? | ☐ Yes ☐ No | | |
| Is the employee currently on workers compensation? | ☐ Yes ☐ No | | |

### Employer's Declaration and Authority

I hereby certify I'm authorised to answer the above on behalf of the employer & all information I've supplied is true & correct. I acknowledge Windsor Income Protection may provide these forms to required representative or third parties necessary to assist the ongoing assessment of the claim.

| | | | | | |
|---|---|---|---|---|---|
| Company name | | | | | |
| Manager/Supervisor name | | Job title | | | |
| Address | | | | | |
| Suburb | | State | | Postcode | |
| Phone number | | Fax No. | | | |
| Email | | | | | |
| Signature | | Date | / / | | |