ATC INSURANCE SOLUTIONS

Protect

CLAIM FORM

Protect Accidental Dental Injury

EXTF046

For injury claims, please use the Protect Injury claim form.

Call ATC Claims 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. Please keep a copy of the completed claim form and attachments for your records.

5. Send, or fax, or scan and email, or deliver your completed form in person to:
   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 _____

Suburb _____ State _____ Postcode _____

Contact telephone _____ Email _____

Name of employer _____ Project name _____

Address _____

Suburb _____ State _____ Postcode _____

Supervisor name _____ Supervisor telephone _____

Payroll contact name _____ Payroll contact telephone _____

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, Authority and Declaration ➲ SECTION A continued

Privacy

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.

I hereby authorise the person named below to act on my behalf in relation to this claim and authorise ATC to discuss and share any relevant information:

Name _____ Date of birth _____ /_____ /_____ Relationship _____

Telephone number _____ Email _____

Declaration

I declare that:

a. the claim I am making for a dental injury IS NOT WORK-RELATED and if my injury is work-related, I have disclosed this clearly in my answers in the Claimant's Statement, 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 _____ /_____ /_____

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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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