Total Claims Solutions

Incolink
Redundancy Insurance Wellbeing

# DENTAL CLAIM FORM

**Dental Discretionary Cover is provided via Incolink's Discretionary Fund and is governed by the Discretionary Guidelines**

**OFFICE USE ONLY** | Claim number | Reference

### COMPLETE THIS FORM IF

You or your dependant have suffered ACCIDENTAL DAMAGE to sound and healthy teeth, **outside working hours**. Incolink guidelines will be followed when assessing this claim.

### FORWARD THIS CLAIM FORM TO

**Total Claims Solutions**
Level 1, 151 Rathdowne Street
Carlton VIC 3053

### FOR CLAIM ENQUIRIES CALL

**Total Claims Solutions**
(03) 9320 8588

### INSTRUCTIONS

**Section A**

The **WORKER** must complete ALL questions in Section A (pages 1–3) of the form.

Incomplete answers and vague information will delay the assessment of the claim.

**Section B**

The **TREATING DENTIST** must complete Section B (pages 4–5) only if Section A is complete.

The worker will be responsible for any fee charged to complete this statement.

### IMPORTANT

The **ORIGINAL** fully completed claim form must be sent with **ALL DOCUMENTS** outlined in the checklist.

### CHECKLIST

- ☐ Proof of dependant(s) – *if any*
- ☐ Rebate Receipts – *if any*
- ☐ Quotation(s)/Invoices(s)
- ☐ Treatment Plan(s) – *if any*

The issue of this form **DOES NOT** constitute admission of liability on our behalf.

## Section A — Worker

### WORKER DETAILS

**1.** Incolink member number

**2.** Are you a union member ☐ No ☐ Yes ▶ Name of union

**3.** Given name(s) | Surname

**4.** Date of birth DD / MM / YYYY

**5.** Address (no PO Box)

**6.** Home phone | **7.** Mobile | **8.** Email

**9.** Marital status ☐ Married ☐ Defacto ☐ Single

**10.** Sex ☐ Male ☐ Female

**11.** Occupation

**12.** Do you require an interpreter ☐ No ☐ Yes ▶ Language

### CLAIMANT DETAILS

**13.** Person claiming

☐ Worker ☐ Spouse/Defacto/Child ▶

- ☐ **Defacto** – Attach a copy of at least one bill confirming the same residence.
- ☐ **Student over 16** – Attach a copy of the student's ID card.

**Dependants means;**

The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months), or the unmarried financially dependant children of the worker up to 16 years of age or up to 25 years of age if a full time student.

**14.** Name of person claiming (if not worker)

**15.** Date of birth DD / MM / YYYY

**PLEASE ATTACH DOCUMENTATION**

## WORKER'S EMPLOYMENT DETAILS

**16.** Name of company

**17.** Phone

**18.** Date commenced

DD / MM / YYYY

**19.** Employment status

☐ Full-time ☐ Part-time ☐ Casual ☐ Apprentice ☐ Working Director ☐ Sub-Contractor

**20.** Are you office-based

☐ Yes ☐ No

**21.** Are you a union delegate

☐ Yes ☐ No

**22.** Are you still employed

☐ Yes ☐ No ▶ Date of termination DD / MM / YYYY

## ACCIDENT DETAILS

**23.** Date of accident

DD / MM / YYYY

**24.** Exact time of accident

HH : MM am / pm

**25.** How did the accident occur and what were the surrounding circumstances

**26.** Describe the damage to your teeth

**27.** Is the damage to a denture, plate or bridge

☐ No ☐ Yes ▶ Dentist or dental technician who fitted them — Phone

Address — Age of denture/plate/bridge

**28.** Where did the accident occur

☐ Home ☐ Work ☐ Travelling to/from work ☐ Other

**29.** Address where accident occurred

**30.** Name of witness(es)

Phone

1.

2.

**31.** Had you consumed any alcohol or drugs in the 8 hours prior to the accident

☐ No ☐ Yes ▶ Location — Amount

**32.** Did the accident occur while training for or playing sport

☐ No ☐ Yes ▶ Club name — Phone

**33.** Details of the dentist you first consulted for this accident

Dentist | Phone | Date treated DD / MM / YYYY

Address

**34.** Details of the dentist who treated you prior to this accident

Dentist | Phone | Date treated DD / MM / YYYY

Address

**PLEASE SIGN DECLARATION – OVER PAGE**

## OTHER BENEFIT DETAILS

**The Incolink Dental Program requires all dental claims to be lodged via your private health insurer or travel insurer in the first instance.**

**35.** Do you have private health insurance

☐ No ☐ Yes ▶ Is dental cover included ☐ No ☐ Yes ▶ Has a claim for this treatment been lodged with this insurer

☐ No ☐ Yes ▶ Please provide rebate receipts

**36.** Did the accident occur overseas

☐ No ☐ Yes ▶ Have you lodged a claim with your travel insurer? ☐ No ☐ Yes ▶ Insurer

Phone

Claim number

**PLEASE ATTACH A COPY OF ALL REBATE SLIPS**

## DECLARATION AND AUTHORISATION

**CLAIMANT;**

I hereby authorise any dentist, employer or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim.

I authorise Total Claims Solutions to give or obtain information relating to my claim from any insurer and/or private health fund, statutory authorities, or their representatives.

I authorise Total Claims Solutions to give or obtain information from my employer.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I understand that supplying false or misleading information will result in my right to compensation being forfeited.

I declare that the information provided on this claim form is to the best of my knowledge and belief to be true in every respect.

**Please note;** If under 18 years of age, a guardian must sign authority.

Signature

Print name

Date DD / MM / YYYY

**WORKER;**

I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

Signature

Print name

Date DD / MM / YYYY

Total Claims Solutions manage the Discretionary Dental Claims on behalf of Incolink

Incolink
Redundancy Insurance Wellbeing

## Section B — Treating Dentist

### PATIENT DETAILS

**THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT**

**1.** Name

**2.** Age

**3.** Occupation

**4.** Address

### ACCIDENT DETAILS

**5.** Date the patient first consulted you

DD / MM / YYYY

**6.** Describe the damage to the tooth/teeth

**7.** Was the damaged tooth/teeth sound and healthy prior to the accident

☐ Yes ☐ No ▶ Provide details

**8.** What damage was caused by the accident

☐ Tooth structure only ☐ Existing restoration only ☐ Both ☐ Other

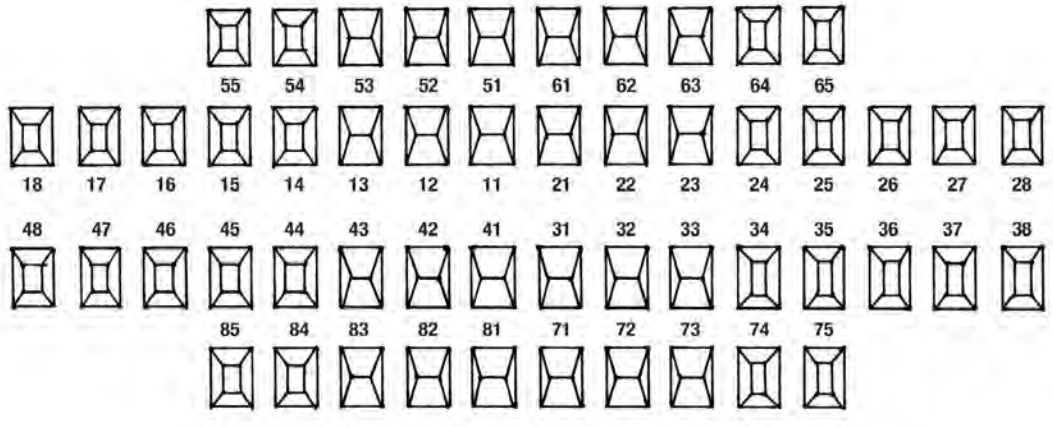
**9.** Did the accident result in damage to a denture/plate/bridge

☐ No ☐ Yes ▶ Were you the dentist who provided them originally ☐ No ☐ Yes Age of denture/plate/bridge

**10.** Type of denture

☐ Acrylic ☐ Cast metal frame ☐ Full upper ☐ Full lower ☐ Partial upper ☐ Partial lower

**11.** On the following diagram, please indicate with an 'X' the damaged tooth/teeth and circle the tooth/teeth of any denture/plate/bridge




**12.** If the patient is a child, was the damage sustained to the milk or permanent tooth/teeth

### TREATMENT DETAILS

**13.** Please give details as to the status of the patient's tooth/teeth

**14.** Has the patient ever had the same or a similar condition

☐ No ☐ Yes ▶ When

Impact on current treatment proposed

**CONTINUE OVERPAGE**

**15.** Is the treatment proposed/performed solely due to the accident

☐ Yes ☐ No ▶ Provide details

**16.** Is any further treatment required

☐ No ☐ Yes ▶ Provide details

**17.** Please advise the circumstances of the patient's accident and how the tooth/teeth was damaged

**18.** Did the accident occur at work

☐ No ☐ Yes ▶ Provide details

**19.** Was the patient playing in competitive sport at the time of the accident

☐ No ☐ Yes ▶ Provide details

**20.** Do you believe the patient was under the influence of alcohol or drugs at the time of the accident

☐ No ☐ Yes ▶ Provide details

**21.** Are you the patient's regular dentist

☐ Yes ☐ No

**22.** Does the patient have Private Dental Insurance

☐ No ☐ Yes ▶ Insurer Phone

## DECLARATION BY DENTIST

**I hereby declare that the information I have provided on this form is to the best of my knowledge and belief, true in every respect.**

Name

Medical qualifications

Signature

Date DD / MM / YYYY

Address

STAMP

Phone

Fax

Email

**PLEASE ATTACH A COPY OF THE TREATMENT PLAN/QUOTATION AND/OR INVOICE**

**Total Claims Solutions Pty Ltd** ABN 42 389 515 023
Acting as Claims Managers on behalf of Incolink
Level 1, 151 Rathdowne Street, Carlton, Victoria 3053
T: (03) 9320 8588
F: (03) 9663 4020

**www.totalclaims.com.au**