Total Claims SOLUTIONS

Incolink Entitlements 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.

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

FORWARD THIS CLAIM FORM TO

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

Or email:
claimsVIC@totalclaims.com.au

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.

This claim must be supported by proof of identity.

Acceptable Documents
1. A current Australian drivers license, or
2. A current Australian passport

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*
- ☐ Proof of identity
- ☐ Proof of bank details

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. Street Address (no PO Box) | Suburb | Postcode

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.
- ☐ **Child under 16** – Attach a copy of the child's birth certificate or Medicare card listing the child.
- ☐ **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

OTHER BENEFIT DETAILS

The Incolink Dental Program requires all dental claims to be lodged through 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 statements

36. Did the accident occur overseas?

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

Phone

Claim number

37. If claiming for your child aged between 2 to 17 years of age, are you eligible to claim the 'Child Dental Benefits Schedule' with Medicare?
If unsure, please check with Medicare if your child is eligible.

☐ Yes ☐ No

PLEASE ATTACH A COPY OF ALL REBATE STATEMENTS

PAYMENT DETAILS

38. If this claim is accepted, how would you like to receive payment (s)

☐ Cheque ☐ Electronic Funds Transfer ▶ Bank name

Account name | Account type

BSB | Account number

I (name in full) ..... hereby authorise QBE Insurance (Australia) Limited and/or Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.

Signature | Date DD / MM / YYYY

We depend on the accuracy of the details you provide.

Please attach proof of
- Account name
- BSB / Account number

to ensure correct details are entered for payment

PLEASE ATTACH PROOF OF BANK DETAILS – FOR EXAMPLE SCREENSHOT OF BANK ACCOUNT

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
Entitlements 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

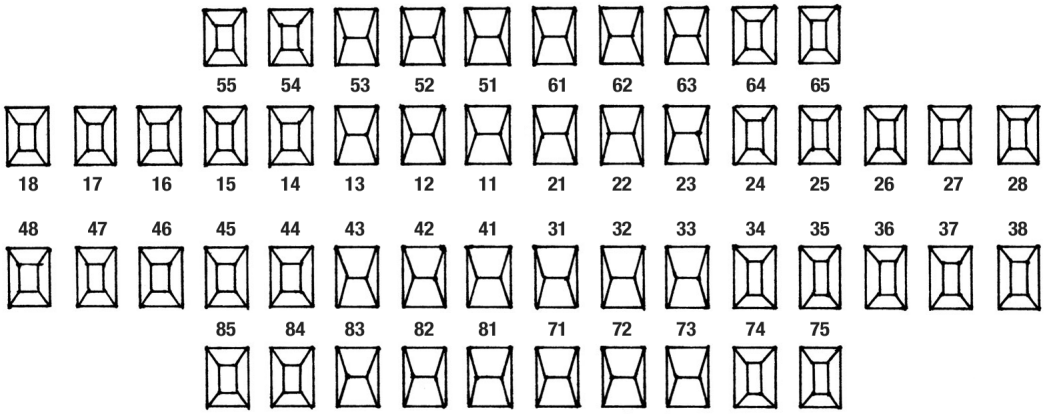
9. Did the accident result in damage to a denture/plate/bridge?

☐ 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 circle the damaged tooth/teeth



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

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

14. Did the accident occur at work?

☐ No ☐ Yes ▶ Provide details

15. Was the patient playing in competitive sport at the time of the accident?

☐ No ☐ Yes ▶ Provide details

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

☐ No ☐ Yes ▶ Provide details

TREATMENT DETAILS

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

18. Has the patient ever had the same or a similar condition?

☐ No ☐ Yes ▶ When

Impact on current treatment proposed

19. Is the treatment proposed/performed solely due to the accident?

☐ Yes ☐ No ▶ Provide details

20. Is any further treatment required?

☐ 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

23. If the patient is a child and aged between 2 to 17 years old, is the patient eligible to claim the 'Child Dental Benefits Schedule' with Medicare?

☐ No ☐ Yes ▶ Please advise amount available towards the treatment

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

Phone

Fax

Email

STAMP

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