

OFFICE USE ONLY	Claim Number	Reference Number

## DENTAL CLAIM FORM

The Incolink Dental Scheme provides cover to the worker and his/her dependants, for ACCIDENTAL DAMAGE to sound and healthy teeth, occurring outside working hours.

**Dependant means;** the Worker's spouse (or partner/defacto with whom the Worker has cohabited for not less than 3 consecutive months) and includes 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.

### INSTRUCTIONS

The form has two parts which need to be fully completed

#### SECTION A WORKERS STATEMENT

The worker needs to complete ALL questions in this section of the form, being the first two pages. Incomplete and vague information will delay the assessment of your claim.

#### SECTION B ATTENDING TREATING DENTIST

The treating Dentist must complete the Attending Treating Dentist statement. Any charge for completion of this statement must be borne by the worker.

#### IMPORTANT

- A claim cannot be assessed until we receive the ORIGINAL claim form, completed in FULL.
- The issue of this form does not constitute an admission to liability on the part of us.

Please forward the claim form to:

**TOTAL CLAIMS SOLUTIONS PTY LTD**  
**A.B.N. 42 389 515 023**  
**Level 1, 151 Rathdowne Street, Carlton, Victoria 3053**  
**PHONE: (03) 9663 2411 FAX: (03) 9663 4020**

## SECTION A WORKER DETAILS

Incolink Member Number		Union (Please tick one)	CFMEU <input type="checkbox"/>	CEPU <input type="checkbox"/>	AMWU <input type="checkbox"/>	OTHER <input type="checkbox"/>
Worker	Surname					
	Given name(s)					
Address (No PO Box)						State
						Postcode
Telephone	Private ( )	Business ( )	Mobile			
Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Occupation	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> De-facto					

## CLAIM DETAILS

Name of the person claiming.	
Date of Birth (person claiming).	____/____/____
Relationship to worker (i.e. son, de-facto)	

If defacto, attach copy of a bill determining you both reside at the above address. If a child is over the age of 16, provide a copy of their Student ID card.

## EMPLOYMENT DETAILS

Name of Company	Telephone ( )
Address	
Are you a	<input type="checkbox"/> Casual <input type="checkbox"/> Part-time <input type="checkbox"/> Full time <input type="checkbox"/> Apprentice
Date commenced with company?	____/____/____
Are you still employed?	<input type="checkbox"/> NO <input type="checkbox"/> YES    If NO when did you cease? ____/____/____

## ACCIDENT DETAILS

Give the exact date and time the accident occurred.	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Time	am/pm
State in full detail exactly how the accident occurred, advising the circumstances surrounding the incident.									
Describe the damage to your teeth									
If the damage is to a Denture/Plate/Bridge, please advise the age and provide the name, address and contact number of the Dentist/Dental Technician who provided them for you.									
Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work Other (give details) _____									
Address where accident occurred?									
Name & Addresses of any witnesses to the accident									
1. Name					Address				
2. Name					Address				
Had you consumed any alcohol or drugs within the 8 hours prior to the accident?								<input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes, amount					Where				
Did the accident occur while training for or playing sport?					<input type="checkbox"/> NO <input type="checkbox"/> YES				
If yes, provide the name of the club									
Please provide the date you first received advice or treatment for this incident, together with the name and address of the dentist you saw.									
Date first treated		<input type="text"/>			Name of Dentist				
Address					Telephone		( )		
Please provide the name, address and telephone number of any Dentist who treated you prior to this accident.									
Name of Dentist					Address				
					Telephone		( )		

## PRIVATE HEALTH INSURANCE DETAILS

Do you have Private Health Insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES		If yes, please advise the name of the Health insurer? _____							
Does your Private Health Insurance Include Dental Cover?					<input type="checkbox"/> NO <input type="checkbox"/> YES				
PLEASE NOTE: It is a condition of the Incolink Dental Scheme that requires you to lodge all dental claims via your private dental insurer first.									
Have you lodged a claim with your Private Health Insurance for this claim? If so, please attach a copy of all rebate slips.								<input type="checkbox"/> NO <input type="checkbox"/> YES	

## AUTHORISATION OF CLAIMANT (If you are under the age of 18, guardian is to sign authority)

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

I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original. I also declare that the information provided on this form is to the best of my knowledge and believe to be true in every aspect. I understand that supplying false or misleading information will result in my right to compensation being forfeited.

Signature		Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
-----------	--	------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

## DECLARATION BY 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		Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
-----------	--	------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM



**SECTION B Continued.**

10. Did the patient's accident occur at work?	<input type="checkbox"/> NO <input type="checkbox"/> YES If "Yes" please provide details.

11. Was the patient playing in competitive sport at the time of his/her accident?	<input type="checkbox"/> NO <input type="checkbox"/> YES If "Yes" please provide details

12. Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident?	<input type="checkbox"/> NO <input type="checkbox"/> YES If "Yes" please provide details

13. Are you the patient's regular Dentist?	<input type="checkbox"/> NO <input type="checkbox"/> YES
--	--

14. Are you aware if the patient has Private Dental Insurance?	<input type="checkbox"/> NO <input type="checkbox"/> YES
--	--

If so, please advise the name of the health insurer and confirm if any rebates have been made.


**I hereby declare that I have personally examined the above named claimant and that in my opinion the statement made in the "Accident Details Section" of this form is consistent with the damaged sustained.**

Signature of Dental Attendant		Date							
Dental Attendant's full name (please print clearly)									
Qualifications									
Address									
Telephone (Business)	(   )								
Facsmilie (Business)	(   )								
E-mail Address									