

**POLICE FEDERATION  
DENTAL INJURY / EMERGENCY  
CLAIM FORM**

<b>Serving Officer</b>		<b>Partner of Serving officer</b>	
<b>Police Staff</b>		<b>Partner of Police Staff</b>	
<b>Special Constable</b>		<b>Partner of Special Constable</b>	
<b>Retired Member</b>		<b>Partner of Retired Member</b>	

To be completed by the Member for whom the benefit is being claimed and returned to:  
**Philip Williams & Co, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW.**  
 The issue of this form is in no way an admission of liability.

**Policyholder / Patient details**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of Police Federation: \_\_\_\_\_

Division: \_\_\_\_\_

Rank: \_\_\_\_\_ Number: \_\_\_\_\_

Name of Patient (if different from policyholder): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Dental Injury / Emergency**

Please indicate whether you are claiming for a dental injury or emergency dental treatment (“Claim”) as defined below:-

**Dental Injury** – an injury to the teeth or supporting structures (including damage to dentures whilst being worn) which is directly caused suddenly and unexpectedly by means of a direct external impact.

Was this as a result of a contact sport? **Yes / No**

If yes, were you wearing a mouth guard? **Yes / No**

**Emergency Dental Treatment** – temporary dental treatment provided at the initial emergency appointment required for the relief of severe pain, arrest of haemorrhage, the control of acute infection or a condition which causes a severe threat to your general health.  
**For the avoidance of doubt any subsequent treatment required after the initial emergency appointment is specifically excluded.**

Please provide full details of the injury/emergency and the treatment completed you are claiming for

**Date of injury/emergency:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **Amount Paid:** \_\_\_\_\_

**Routine / Restorative treatment details**

(Please continue on a separate sheet if needed and attach itemised receipts confirming payment)

Please list all treatment that is being claimed for	NHS	Private	Abroad	Treatment Date	Amount £

**Other treatment details** (Further details will be required and we will contact you as soon as possible)

**Hospital Cash Benefit**    Date of admission \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of discharge \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mouth Cancer cover**    Date of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of treatment \_\_\_\_/\_\_\_\_/\_\_\_\_

**Call out fees**    Time of call out \_\_\_\_ : \_\_\_\_ AM / PM    Date of call out \_\_\_\_/\_\_\_\_/\_\_\_\_

**Treating Dentist details**

Name of Dentist: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

Address of Practice: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Practice Telephone Number: \_\_\_\_\_

Dentist GDC No: \_\_\_\_\_

**Claiming Checklist**

In order for your claim to go through successfully please ensure that: -

- You have fully completed all sections of this claim form
- The **patient** has signed the declaration
- You have used one claim form per person
- You have attached fully itemised receipt(s) showing proof of payment and a breakdown of the treatment
- If the patient has received NHS dental treatment or dental emergency treatment, please make sure this is clearly stated on this claim form and your itemised receipt

**Declaration**

I declare that the information given on this form is true and complete to the best of my knowledge.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I confirm that I have been informed of my rights under the Access to Medical Reports Act and consent to the underwriters to whom the claim is submitted (the underwriters) seeking medical information from any medical practitioner who has treated me or who has access to records relating to my physical and mental health, or any other source which is necessary and relevant in the opinion of the Underwriter's Chief Medical Officer.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I do/do not\*** wish to see any medical reports prior to their release to the Insurers.

**\*Delete as applicable**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I also consent to the release of such information to the Underwriter's Chief Medical Officer.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I understand and consent to the use of this information provided on this form, together with medical and other information provided in connection with any claim, for the purposes of underwriting, administration, claim management, rehabilitation and customer concern handling. In order to do this, the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY PHILIP WILLIAMS & CO:**

**I certify that the claimant is a member of the Scheme and that the claim details are correct.**

**Date of Joining Scheme:-** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

## **BANK DETAILS**

**When your claim has been approved we will make the payment to you directly to your Bank Account.**

**Please complete the following: -**

**Name and address of your Bank:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Branch Sort Code:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Account Number:** \_\_\_\_\_

**Account Name(s):** \_\_\_\_\_

## **DATA PROTECTION NOTICE**

Philip Williams & Company Insurance Management collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) ("data protection law"). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams & Company Insurance Management using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at <https://www.philipwilliams.co.uk>

## **ACCESS TO MEDICAL REPORTS ACT 1988**

### **Rights and Procedures**

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration on this form. Before you sign, you should read this section carefully. It details your rights under the Act.

1. You do not have to give your consent. If you do not give your consent, we may be unable to proceed with your claim.
2. You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request in writing. You will then have 21 days to arrange with the doctor to see the report. If you haven't arranged to see the report within this period the doctor will send it to us.
3. If you indicate that you don't want to see the report, we do not have to tell you if we apply for one. You can, however, ask to see a copy of the report within six months of it being sent to us.
4. The doctor may charge you a reasonable fee if you ask to see a copy of the report.
5. If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can, however, refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.
6. The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to:
  - Adversely affect your physical or mental health or that of others,
  - Indicate the doctor's intentions to you,
  - Reveal the identity of a third party who has given information about you unless they have consented to its disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your claim.