

# Claim for mouth cancer cover and hospital cash

## Supplementary Insurance/Denplan Emergency – Benefit F

Before completing this form please read the terms and conditions in your policy document. To help us settle your claim quickly please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

Please make reasonable efforts to ask your treating consultant to complete the information required concerning any treatment and advice that you've received. If there is any difficulty in doing this, do not delay in returning the form to us.

Please be aware we may need your dental records to support your claim.

Office use only. Claim reference number.

If you've any questions please call a member of our Insurance team free from a UK landline on 0800 085 0960. Please send your completed form, within 60 days of positive diagnosis where reasonably possible, to us at Insurance Department, Denplan Limited, Denplan Court, Victoria Road, Winchester, Hampshire, SO23 7RG.

### Patient details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Patient Denplan registration number

Mr  Mrs  Miss  Other

Date of birth

First name

Surname

House name or number

Address

Town or city

County

Postcode

Is this your permanent address? Yes  No

Home phone number

Work phone number

Email address

We may use this email address to advise you of confidential information about your insurance claim. If you would prefer not to be contacted in this way, please leave this box blank. If you would prefer to receive your regular Denplan membership correspondence by email, please tick

### Hospital and treatment details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Date of admission

Time  :  AM  PM

Date of treatment

Date of discharge

Time  :  AM  PM

If your stay exceeded 5 days, please provide a copy of your admittance and discharge form or any other supporting evidence

Please provide the name and address of the hospital where you were treated

Postcode

Name of consultant

Specialism

Please give a description of treatment/consultation given

Please turn over

## Treatment section

To be completed by the Specialist or referring General Practitioner

Please provide the name and address of the hospital where the treatment took place

Hospital name

Hospital address

Postcode

Where is the primary site of the cancer?

On what date did the patient first become aware of the symptoms?

D D M M Y Y Y Y

Please describe the treatment provided

What was the date of diagnosis?

D D M M Y Y Y Y

Does the treatment relate to tests or consultations for non-invasive tumours? Yes  No

Please describe any further treatment that may be planned

## Patient's declaration

To be completed by the patient (or parent/guardian of a patient under 16 years)

I confirm that I am the patient (patient's parent or guardian if under 16 years of age) and I declare that the information provided on this form is true and complete. I hereby consent to and authorise the General Practitioner and/or any Specialist involved in my/the patient's care to discuss treatment details and discharge arrangements with Denplan Limited. I understand that Denplan Ltd, on behalf of the Insurers, reserves the right to appoint an examiner or make such other enquiries as it considers appropriate before agreeing any claim.

I declare that the mouth cancer was not:

- diagnosed before I joined Denplan
- diagnosed within 90 days after the date I was provided with mouth cancer cover, or for which tests or consultations began within those 90 days
- caused as a result of chewing tobacco products, betel nut or prolonged alcohol abuse
- found in the tonsils

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date

D D M M Y Y Y Y

## Medical practitioner's declaration

I declare that I am the patient's Specialist (or General Practitioner), that the patient was referred to me by his/her General Practitioner, and that the information given is, to the best of my knowledge, true and correct.

Name

Signature

Date

D D M M Y Y Y Y

Title

Are you a Consultant Maxillofacial Surgeon? Yes  No

If 'No' please give details of your medical specialism

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK.

Tel: 0800 587 6578. Fax: 01962 849932. Email: trauma@denplan.co.uk

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