

# 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

**DEPENDANT DETAILS**

13. Do you have dependants  No  Yes  Status of Dependant(s)  Spouse/Defacto (Attach a home bill showing both the members name and wife/defacto's name)  Child (under 16 years old, attach a copy of the birth certificate or Medicare card listing the child)  Child (over the age of 16 years old, attach a copy of the student ID card)

Please note only one proof of dependant information is required. Limitations will apply for worker with and without dependants (refer to the Incolink Accident & Illness Benefits Brochure)

**CLAIMANT DETAILS**

14. Name of person claiming (if not worker)  15. Date of birth  DD / MM / YYYY

If spouse/defacto or child is claiming, please provide supporting documents (refer question 13 above).

**PLEASE ATTACH DOCUMENTATION**

**WORKER'S EMPLOYMENT DETAILS**

16. Name of company

17. Phone

18. Date commenced

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

**ACCIDENT DETAILS**

23. Date of accident

24. Exact time of accident

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

Address

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

Dentist

Phone

Date treated

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

**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

Total Claims Solutions manage all Discretionary Cover claims on behalf of Incolink



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

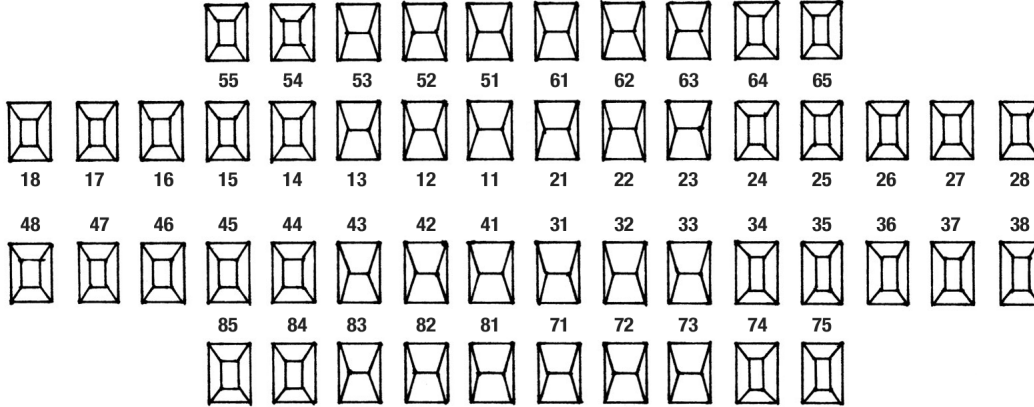
9. Did the accident result in damage to a denture/plate/bridge

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

Dashed box for providing details for question 15.

16. Is any further treatment required

No  Yes  Provide details

Dashed box for providing details for question 16.

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

Two solid rectangular boxes for providing details for question 17.

18. Did the accident occur at work

No  Yes  Provide details

Dashed box for providing details for question 18.

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

No  Yes  Provide details

Dashed box for providing details for question 19.

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

No  Yes  Provide details

Dashed box for providing details for question 20.

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.

Form fields for Name, Medical qualifications, Signature, Date, Address, Phone, Fax, Email, and a large box for a STAMP.

**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  
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