Total Claims Solutions

CFMEU Union

OFFICE USE ONLY	Claim Number	Reference Number

DENTAL CLAIM FORM

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

Dependant means; the Worker's spouse (or partner 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 6, 101 Wickham Terrace, Brisbane, QLD 4000
PHONE: (07) 3832 4842 FAX: (07) 3839 8500
FREECALL: 1800 442 664

SECTION A WORKER DETAILS

Union Membership Number		BUSSQ No:			
Union (Please tick one)	☐ CFMEU	☐ CEPU	☐ BLF	☐ OTHER	
Worker	Surname				
	Given name(s)				
Address (No PO Box)					
		State		Postcode	
Telephone	Private ( )	Business ( )		Mobile	
Date of Birth		Sex ☐ M ☐ F		Occupation	
Marital Status	☐ Single	☐ Married	☐ 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	☐ Casual ☐ Part-time ☐ Full time ☐ Apprentice		
Date commenced with company?	______/_____/______		
Are you still employed?	☐ NO ☐ YES If NO when did you cease? ______/______/_____		

ACCIDENT DETAILS

Give the exact date and time the accident occurred. Date ___ 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 Techician who provided them for you.

Where did the accident occur? ☐ Home ☐ 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? ☐ NO ☐ YES

If yes, amount ___ Where ___

Did the accident occur while training for or playing sport? ☐ NO ☐ 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 ___ 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? ☐ NO ☐ YES If yes, please advise the name of the Health insurer? ___

Does your Private Health Insurance Include Dental Cover? ☐ NO ☐ YES

PLEASE NOTE: It is a condition of the BERT 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. ☐ NO ☐ 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 ___

DECLARATION BY WORKER

I hereby authorise my union and administrator to furnish Total Claims Solutions Pty Ltd with details of my union and employer payments to assist with the claim.

Signature ___ Date ___

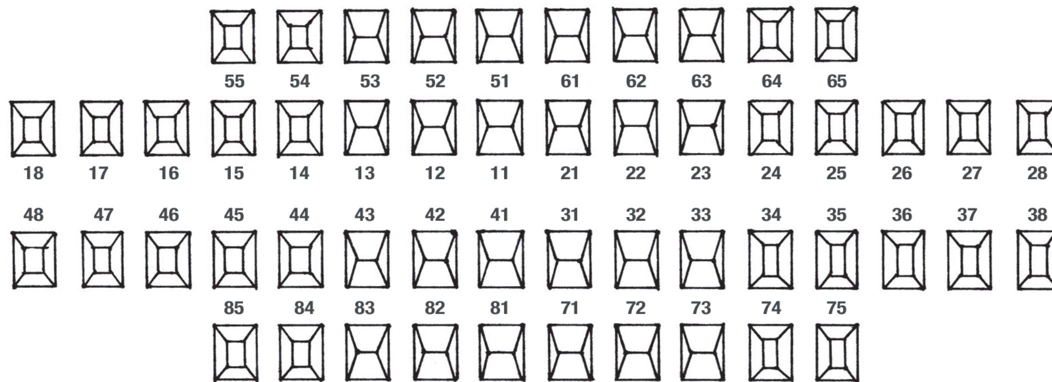
PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM

SECTION B TO BE COMPLETED BY YOUR TREATING DENTIST

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

Patient's Name	Age	Occupation	Patient's Address

1. Describe the damage to the patient's tooth/teeth and indicate an X on the following diagram the tooth/teeth in question. Please also advise if only the tooth structure or if the existing restoration was damaged, or both.



2. If the incident resulted in the patient's damaged denture/plate/bridge, please confirm the age and if you were the dentist who provided them originally. Please indicate on the above chart which teeth are involved in the denture/plate/bridge.

Please tick the type of Denture ☐ Acrylic ☐ Castmetal frame ☐ Full upper ☐ Full lower ☐ Parital upper ☐ Partial lower

3. If the patient is a child, is the damage sustained to the child's milk tooth/teeth or permanent tooth/teeth?

4. Was the damaged tooth/teeth sound and healthy prior to the accident? ☐ NO ☐ YES If, no please explain.

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

6. Has the patient ever had the same or similar condition? If "Yes" state when and describe whether this has an impact on current treatment proposed ☐ NO ☐ YES

7. Is the treatment proposed/performed solely due to the accident? If not, please explain.

8. When did the patient first consult you for this dental work?

9. What did the patient tell you, as to how the accident occurred. Please include the circumstances surrounding how the teeth/tooth was damaged.

SECTION B Continued.

10. Did the patient's accident occur at work?	☐ NO ☐ YES If "Yes" please provide details.

11. Was the patient playing in competitive sport at the time of his/her accident?	☐ NO ☐ 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?	☐ NO ☐ YES If "Yes" please provide details

13. Are you the patient's regular Dentist?	☐ NO ☐ YES
14. Are you aware if the patient has Private Dental Insurance?	☐ NO ☐ 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			

PLEASE PROVIDE A COPY OF THE ACCOUNT/ INVOICE OR QUOTATION/TREATMENT PLAN.