BRITISH TRANSPORT POLICE FEDERATION PERSONAL ACCIDENT CLAIM FORM - DENTAL INJURY

OFFICER INSURANCE COVER

By **Advisory Insurance Brokers Limited** (part of The Ardonagh Group)

Complete this form and return it to:
British Transport Police Federation, 134 Thurlow Road, West Dulwich, London SE21 8HN
Use additional sheets if you need to provide further information.

Worldwide Dental Injury- Cover is for dental treatment and prescription charges incurred in connection with a dental injury. Benefit is only in respect of treatments commencing within 183 days, and completed within 2 years, of the date of the accident.

PLEASE COMPLETE IN BLOCK CAPITALS

Mr ☐ Mrs ☐ Ms ☐ Miss ☐

Surname:		Forename(s):	
Date of birth:		Collar no:	
Warrant no:		Rank:	
Station:			
Home Address:			
Telephone no:		Email:	
Date and location of accident:			
Approx time:			

Please provide a full description of your accident, the injuries and also how the injuries were sustained:

Please give details if you required a dentist call out / emergency treatments / temporary treatments following the accident?

Name/Address and contact telephone number for dentist(s) providing treatment:

Please give details of treatment received to date.

Please give details of further treatment required in the future as a result of the dental injury.

Any additional information.

Did treatment involve or will it later require you to stay in hospital overnight? Yes ☐ No ☐

If you required a hospital admission overnight stay or will need to in the future and this is a direct result of your dental injury, you may be entitled to receive hospital benefit (max' 20 nights); complete a hospital benefit claim form.

Dental call out costs	
Emergency /Temporary Treatments costs	
Other costs incurred to date	
Amount of dentist quote for future treatment plans	
Any other costs claimed	

Please attach all receipts and quote details to the claim form together with any medical reports.

I certify that I was a subscribing member of the scheme on the date of the accident and to the best of my knowledge the statements made are true and without reservation. I agree that the information on this form, including sensitive (medical) information, may be stored and shared with British Transport Police Federation, the insurers/underwriters, their agents and the scheme brokers, but only for the purposes of processing and recording my claim.

Signed: Date:

Please note that in order to assess your claim we may need to contact your dentist or specialist to obtain further reports. By proceeding with this claim you signify your consent to this.

Benefit payments are made to your bank account; please complete the following:

Bank name and address:

Branch sort code:

Account name:

Account number:

This claim form must be submitted by the Federation office. By submitting this claim via email to Advisory Insurance Brokers Limited, we hereby confirm that the claimant was a member of our Group Scheme at the date of the incident and is therefore an eligible claimant.

Advisory Insurance Brokers Limited are acting on behalf of insurers, which enables us to handle certain claims on their behalf.

Data Protection Notice: Group Insurance Scheme Cover is arranged by Advisory Insurance Brokers Limited, who are the data controller for the personal information you provide. We are committed to keeping your information safe and secure. We will use your personal information to communicate with you and to provide you with the products and services you have requested or are of interest. We share information with other companies including insurers and finance companies to assess and obtain the quotes and covers you have requested. We will also share information with other organisations where we need to do so by law. Our Fair Processing Notice can be found here: **https://www.towergateinsurance.co.uk/fpn/advisory-insurance-brokers**. This explains in more detail how we use and share your personal information.

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