Redundancy claim form

Reference to the supplementary insurance policy document will assist you in completing this form. Should you require any assistance, please feel free to call the PPD insurance team on 01482 213215.

This form, countersigned by the treating dentist must be sent to the insurance team at PPD within 30 days of the injury, incident or emergency (60 days if the incident occurs overseas). Costs will be reimbursed up to the limits shown in the policy. PPD will at its sole discretion settle the claim directly either to you or to the treating dentist. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist. You must provide all necessary reports, receipts, and other documentation in support of the claim when asked to do so.

1. Patient details

Full name	
Address	
Postcode	
Telephone	
Email	
Date of birth	
Plan registration number	

2. Registered dentist details

Full name	
Practice name	
Address	
Postcode	
Telephone	
Email	

3. Claim information

1. Please advise the date that you were first made aware of possible redundancy?

   / /

2. Please advise your employment status immediately prior to being made redundant?

3. Please provide us with a formal letter from your employer confirming the redundancy.
4. Please provide us with documentary evidence to confirm that you are actively seeking alternative employment e.g. evidence of your attendance at your local job centre.
5. Please provide us with documentary evidence to show that you are in receipt of unemployment benefit per calendar month.

4. Data protection

By signing this form you consent to Hiscox using the information we may hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities.

Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998.
You have the right to apply for a copy of your information (for which we may charge a small

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You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

5. Declarations

i. Dentist declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name

Signature

Date / /

ii. Patient declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of my claim have been disclosed.

I/We understand that non-disclosure or misrepresentation of a material fact or matter will entitle the insurer to avoid this insurance.

Signature

Date / /

Please return this form to:

Patient Plan Direct Claims
Partnership House
Priory Park
East Hull HU4 7D
Tel: 01482 213215
Email: ppd@insurance-partnership.com