

BERT Dental Claim Form



Please return this completed form to:

Email: claims@bert.com.au | SMS: 0428 483 324 | Post: BERT, PO Box 805, SPRING HILL QLD 4004

Office: Level 1, 35 Astor Terrace, SPRING HILL QLD 4000

The BERT Dental Scheme provides cover to worker's and their dependants, for ACCIDENTAL DAMAGE to sound and healthy teeth, occurring 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 the 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.

SECTION A WORKERS STATEMENT

PERSONAL DETAILS

Surname	<input type="text"/>	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms										
Given name	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Street address	<input type="text"/>														
Suburb	<input type="text"/>	State	<input type="text"/>	<input type="text"/>	Postcode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Postal address (Write 'AS ABOVE' if same as Street address)	<input type="text"/>														
Suburb	<input type="text"/>	State	<input type="text"/>	<input type="text"/>	Postcode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Telephone	Home	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Mobile	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>														
BERT Member No. (if known)	<input type="text"/>	Union	<input type="checkbox"/> CFMEU	<input type="checkbox"/> CEPU	Union No. (if known)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PAYMENT DETAILS

Electronic Funds Transfer (EFT) is the quickest and most effective way to receive your benefit.

1. Please indicate your preferred method of payment for your claim:

EFT Cheque (All cheques will be sent to your above address) (Please proceed to question 2)

To receive payment via EFT, we require a copy of your bank statement which clearly displays the following:

Name of Bank	<input type="text"/>	BSB Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Account Name	<input type="text"/>	Account Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please note: If details provided are incomplete, insufficient, illegible or incorrect a cheque will be issued.

CLAIMANT DETAILS

Surname	<input type="text"/>	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms				
Given names	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to Member	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse	<input type="checkbox"/> Defacto	<input type="checkbox"/> Child	<input type="checkbox"/> Dependant Child				

EMPLOYMENT DETAILS

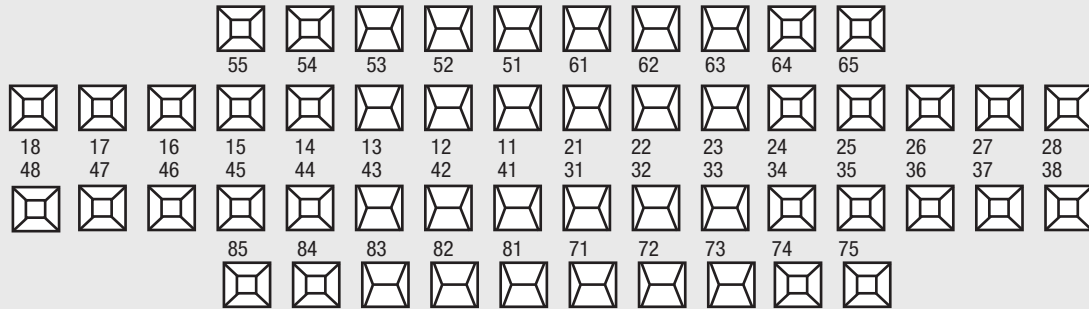
Trading Name of Employer	<input type="text"/>								
Street address	<input type="text"/>								
Suburb	<input type="text"/>	State	<input type="text"/>	<input type="text"/>	Postcode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION B ATTENDING TREATING DENTIST - THIS SECTION TO BE COMPLETED BY YOUR TREATING DENTIST

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

Patient's Name

Describe the damage to the patient's tooth/teeth and indicate an X on the below diagram the tooth/teeth in question.



If the incident resulted in the patient's damaged denture/plate/bridge, please confirm the age of the dentures/plate/bridge 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

Type of Denture Acrylic Cast metal frame Full upper Full lower Partial upper Partial lower

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

Prior to the accident, was the damaged tooth/teeth sound and healthy? Yes No If no, please provide details below

Has the patient ever had the same or similar condition? Yes No

If yes, state when and describe whether this has an impact on current treatment proposed.

Is the treatment proposed / performed solely due to the accident? Yes No If no, please explain below

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

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

Did the patient's accident occur at work? Yes No If yes, please provide details

Was the patient's playing competitive sport at the time of the accident? Yes No If yes, please provide details

Are you the patient's regular dentist? Yes No

Are you aware if the patient has Private Health Insurance? Yes No

If yes, please advise the name of the Health Insurer and confirm if any rebates have been made

DECLARATION

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 damage sustained

Signature of Dentist

Date

**PLEASE PROVIDE A COPY OF A QUOTATION,
TREATMENT PLAN AND/OR INVOICE AND ACCOUNT**

CHECKLIST

Before sending your form into the BERT Office please ensure you have read and checked the below requirements for your Dental Claim

Have you completed and Signed Section A of the Form

Has your treating Dentist completed and Signed Section B of the Form

Have you or your treating Dentist provided a quote / treatment plan and/or invoice / account

The BERT Dental Scheme provides coverage for the cost of dental work for accidental damage to sound and healthy teeth, up to the amount of \$3,000 in any one financial year for all financial members of the:

- a) Construction Forestry Mining & Energy Union (Queensland / Northern Territory Construction & General Division Branch)
- b) Plumbers Union Qld / Northern Territory

Cover ceases immediately once a member is not a financial member of the above Union(s).

Were you a financial member of one of the above mentioned Unions at the Date & Time of the accident

Have you lodged your claim within six (6) months from the Date of accident

No claims for dental damage will be accepted which are a result of *(not a complete list):*

- Failed treatment
- An illegal act
- Childbirth or pregnancy or their complications;
- Disease or sickness;
- An incident sustained at work or via a motor vehicle accident for which statutory insurance provides compensation (i.e. WorkCover; CTP Insurance)
- An incident sustained when training for or playing in competitive club sport or activity organised by any sporting organisation, authority or club;
- An incident sustained from the use of intoxicating liquor or drugs, unless prescribed by a medical practitioner and used as per the medical instructions
- Damage that is to temporary caps or fillings;
- Damage to milk teeth or first teeth;
- Extraction of wisdom teeth;
- Damage to dentures, bridges or plates that are more than 15 years old.

NOTE: For all incidents and damage caused to dentures, bridges and plates between the age of 10 and 15 years BERT will consider a contribution towards the damage based on the age of the denture/bridge.



If you require assistance please call BERT on **1300 261 114**.



Or email us at claims@bert.com.au

Office use only

Entered By (Initial)

Date

D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y

Authorised By (Initial)

Date

D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y

