



WOODBURY DENTAL PRACTICE®
149 HIGH STREET, TENTERDEN, KENT. TN30 6JS
TEL: 01580 762323 FAX: 01580 766140
CENTRE FOR COSMETIC AND RECONSTRUCTIVE DENTISTRY™

DENTAL ACCIDENT AND EMERGENCY COVER

Operational Procedures for Dentists (or Practices)

1. The individual premium rate will be that advised to dentists (or practices) by CCRD. The effective date of any change to such rate will be a minimum of three months by written notice to dentists (or practices) by CCRD.
2. Premium protection will be undertaken annually in advance by the dentist (or practice) and passed immediately to CCRD at Woodbury Dental Practice 149 High Street Tenterden TN30 6JS.
3. Dentists (or practices) will be responsible for advising CCRD in an agreed format of
 - a) Initial membership details (which should accompany the first premium payment).
 - b) Any scheme leavers and the applicable date of leaving.

This information will be passed to CCRD by the dentist (or practice) on a monthly basis.

4. Claim forms are available from CCRD on 01580 762323 down load from our web site: www.dentalinsurance.co.uk Forms must be completed in part by the patient and in part by the dentist. On completion of treatment settlement of claims are made by cheque either to the patient or directly to the dentist. Reimbursement is subject to full completion of a claim form and any shortfall between the amount claimed and the reimbursement amount is the responsibility of the patient.
5. If you have any queries please contact Claims Handling Department at CCRD on 01580 762323 stating that you are calling from a practice covered under the CCRD scheme.

General Terms and Conditions

Policy period

Your policy period is for twelve months commencing on the date advised to you by your dentist and agreed by CCRD.

Should you wish to cancel your cover at any time by written notice to your dentist there will be no pro rata refund of premium to you should your policy be cancelled before the end of the relevant twelve month period.

Premiums

Your dentist will collect premiums from you annually in advance. Your cover will not commence or continue until such premium is received by CCRD.

Claims

You should pay your dentist when your treatment has been completed and submit your claim form. Alternatively if your dentist would prefer us to settle the claim directly with the practice please indicate this on the claim form. Claims forms are obtainable either from your dentist or down loaded as a PDF file from www.dentalinsurance.co.uk web site

In either case reimbursement will be made in accordance with the benefit schedule and any shortfall between the amount claimed and the reimbursement amount is the responsibility of the patient.

Claims must be received CCRD within forty-five days of completion of the treatment.

In an event of a claim for overseas treatment you will need to ask for the invoice/receipt to be written in English. On return to the UK you should forward it to the claims address. You will be reimbursed at the equivalent UK benefit scale as applicable using the exchange rate in force at the date the claim is settled.

Exclusions

Section 1

- Any treatment other than a dental accident or emergency carried out by your own dentist or by any dentist who has an arrangement with your dentist. For this purpose a dentist will be considered to have an arrangement with your dentist if they are a partner expense-sharing colleague associate assistant or locum for your dentist or have any arrangement with your dentist to provide emergency treatment to your dentist's patients.

Section 4

- Any accident or injury caused by the consumption of foodstuffs or beverages including any foreign bodies therein.
- Normal wear and tear.
- Injury whilst participating in any recognised contact sport unless you can evidence that appropriate mouth protection was being worn.
- Any damage which is not apparent within ten days of the date of impact.
- Any self-inflicted damage including damage caused by tooth brushing or the use of other oral hygiene products.
- Any damage to dentures other than while being worn by you.

All sections

- reimbursement of any communication or travelling costs incurred in relation to seeking advice or treatment except as outlined in Section 2 of the benefit schedule.
- Any treatment administered by other than a registered dental practitioner at a registered dental practice.

General**All sections.**

Prior authorisation is required from CCRD on 01580 762323 for fees over £150.00

Crown or bridge replacement will be of the same type and quality.

Where implants are used they will be covered to the value of the equivalent bridgework.

You will be responsible for any changes that may be made by the dentist for the completion of any claim forms.

The cover is not transferable from one dentist to another. In the event of cancellation with your original dentist you will need to restart cover with your new dentist if they are able to provide you with this specific cover.

Complaints procedure

Any enquiry or complaint should be addressed in the first instance to Woodbury Dental Practice. If you are not satisfied with the way a complaint has been dealt with you may ask the Complaints and Advisory Department at Lineglobal Ltd to review your case without prejudice to your rights in law. The address is 2 Eastwell Meadows, Tenterden, Kent, TN30 6QR

DENTAL ACCIDENT AND EMERGENCY CLAIM FORM

To be used to make a claim for: Emergency Treatment Emergency Call Out/Consultation or Overseas Emergency.

Important: Please refer to the benefit schedule to ensure that you are fully aware of the cover available.

How to make a claim

1. Complete the "Patient" section of this form marking clearly to whom reimbursement should be made (Patient or Dentist).
2. Ask the Dentist to complete the "Dentist" section of this form.
3. Send the form (and receipt if applicable) to:

Centre for Cosmetic and Reconstructive Dentistry
149 High Street
Tenterden
Kent
TN30 6JS

Please note that all claims must be submitted within 45 days of treatment. Your reimbursement cheque will be sent to your home address. Should you have any queries regarding your claim please telephone 01580 762323.

This section to be completed by the patient

Patients Name	Title
Home Address	
Postcode	
Date of Birth	
Daytime Telephone No.	
To Whom should reimbursement be made?	
The Patient	Please attach receipts for the amount you have paid.
The Dentist	Please ensure the dentist completes full details on reverse of this form

Declaration

I declare that all the information provided on this form is true and complete.

I hereby authorise any Dentist who examined me to provide CCRD with any information concerning the above. I understand that CCRD reserves the right to make any relevant enquiries before assessing this claim.

Patients signature

Date

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This section to be completed by the Dentist

SECTION 1: EMERGENCY TREATMENT	Unit	Cost	SECTION 2: EMERGENCY CONSULTATION	Cost	SECTION 3: OVERSEAS EMERGENCY TREATMENT	Cost
Examination and treatment of sensitivity		£	TELEPHONE CONSULTATION		Examination and treatment of sensitivity	
X-rays		£	Details incl. date and time	£	X-rays	
Tooth Extraction		£			Tooth Extraction	
Root extirpation inc. dressing and treatment of infection (1 canal)		£			Root extirpation inc. dressing and treatment of infection (1 canal)	
Root extirpation inc. dressing and treatment of infection (2 canals)		£			Root extirpation inc. dressing and treatment of infection (2 canals)	
Root extirpation inc. dressing and treatment of infection (3 canals)		£			Root extirpation inc. dressing and treatment of infection (3 canals)	
Treatment of infection inc. prescriptions		£			Treatment of infection inc. prescriptions	
Investigation and dressing (1st tooth)		£			Investigation and dressing (1st tooth)	
Investigation and dressing (for each additional tooth)		£			Investigation and dressing (for each additional tooth)	
Re-cement crown or inlay		£			Re-cement crown or inlay	
Re-cement bridge		£			CALL OUT	
Provision and fitting of temporary crown		£	Details incl. date and time	£	Provision and fitting of temporary crown	
Provision and fitting of temporary post and core		£			Provision and fitting of temporary post and core	
Provision and fitting of temporary bridge		£			Provision and fitting of temporary bridge	
Treatment to stop haemorrhage incl. aftercare and suture removal		£			Treatment to stop haemorrhage incl. aftercare and suture removal	
Removal of sutures inserted by another practitioner		£			Removal of sutures inserted by another practitioner	
Repair/adjustment of orthodontic appliance		£			Repair/adjustment of orthodontic appliance	
Denture adjustment		£			Denture adjustment	
Repair of denture to include re-fixing of teeth and gums and repair clasp		£			Repair of denture to include re-fixing of teeth and gums and repair clasp	
Any other temporary emergency treatment		£			Any other temporary emergency treatment	
	Total Cost	£			Total Cost	£

Date Treatment Commenced	Dentists Stamp & Signature
Date Treatment Completed	
Dentists Telephone No.	
	Date

DENTAL ACCIDENT AND EMERGENCY CLAIM FORM

To be used to make a claim for: Accident Treatment

Important: Please refer to the benefit schedule to ensure that you are fully aware of the cover available.

How to make a claim

1. Complete the "Patient " section of this form marking clearly to whom reimbursement should be made (Patient or Dentist).
2. Ask the Dentist to complete the "Dentist" section of this form.
3. Send the form (and receipt if applicable) to: CCRD 149 High Street Tenterden Kent TN30 6JS

Please note that all claims must be submitted with 45 days of completion of treatment. Your reimbursement cheque will be sent to your home address. Should you have any queries regarding your claim please telephone 01580 762323

This section to be completed by the Patient

Patients Name	Title
Home address	
Postcode	
Date of Birth	
Daytime Telephone No.	
<p>To whom should reimbursement be made?</p> <p style="text-align: center;">The Patient</p> <p style="text-align: center;">The Dentist</p> <p align="center">Please ensure the dentist completes full details on the reverse of this form. Please attach receipts for the amount you for the amount you have paid.</p>	
<p>SECTION 4: ACCIDENT TREATMENT</p> <p>Details of accident.....</p>	<p>Date.....</p> <p>Time.....</p> <p>Place.....</p> <hr/> <p>What damage did you notice.....</p>
<p>Name and address of first witness.....</p>	<p>Name and address of any additional witness.....</p>
<p>Are you covered by any other insurance relative to this incident? (delete where applicable) *Yes/No</p> <p>If Yes please provide details.....</p>	<p>Was the incident reported to any authority (eg. Police) (delete where applicable) *Yes/No</p> <p>If Yes please provide details.....</p>

Declaration

I declare that the dental injury was caused by direct extra-oral impact and that all the information I have provided on this form is true and complete.

I hereby authorise any dentist to provide CCRD with any information concerning the above. I understand that CCRD reserves the right to make any relevant enquiries before assessing this claim.

Patients signature

Date

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This section to be completed by the Dentist

Treatment	Units	Cost
Examination and report to include necessary smoothing and polishing		£
X-rays		£
Porcelain jacket crown		£
Ceramic bonded crown		£
Metal bonded porcelain crown		£
Post and core construction		£
Full metal crown		£
All metal bridgework - retainer		£
All metal bridgework - pontic		
Bonded metal/porcelain - retainer		£
Bonded metal/porcelain - pontic		
Adhesive bridge - retainer		£
Adhesive bridge - pontic		£
Adhesive facing or veneer		£
Root canal treatment - incisor		£
Root canal treatment - canine		£
Root canal treatment - premolar		£
Root canal treatment - molar		£
Permanent acrylic denture		£
Permanent metal denture		£
Temporary denture following tooth loss		£
Laboratory made temporary bridge following tooth loss		£
Additional unit to bridge		£
Any other necessary treatment		£
	Total Cost	

Date treatment commenced	Dentists stamp and signature
Date treatment completed	
Please indicate NHS or Private	
Dentists telephone number	Date

Section 3- Overseas Emergency Dental Treatment

The purpose of this section is to provide cover if you suffer a dental emergency outside of the U.K. You may claim against the cost of any temporary treatment that is required. Reimbursement will be made according to the individual emergency maximum reimbursements shown in section 1 of this benefit schedule and subject to an overall limit of £325 per incident with a maximum of £650 per policy period.

Section 4 - Accident Treatment

The purpose of this section is to cover the cost of treatment for dental injury caused by external force including damage to any prostheses (eg dentures) sustained whilst in the mouth. The cover is not available for any subsequent permanent or routine treatment.

	Maximum Reimbursement
Examination and report to include necessary smoothing and polishing (per incident)	£ 23.75
X-rays (per incident)	£ 18.00
Porcelain jacket crown (per tooth)	£ 206.00
Ceramic bonded crown (per tooth)	£ 271.75
Metal bonded porcelain crown (per tooth)	£ 245.00
Post and core construction (per tooth)	£ 51.50
Full metal crown (per tooth)	£ 244.00
All metal bridgework (per retainer)	£ 225.00
All metal bridgework (per pontic)	£ 174.00
Bonded metal/porcelain (per retainer)	£ 247.00
Bonded metal/porcelain (per pontic)	£ 212.75
Adhesive bridge (per retainer)	£ 168.75
Adhesive bridge (per pontic)	£ 176.25
Adhesive facing or veneer	£ 215.00
Root canal treatment - incisor (per tooth)	£ 93.50
Root canal treatment - canine (per tooth)	£ 93.50
Root canal treatment - premolar (per tooth)	£ 117.25
Root canal treatment - molar (per tooth)	£ 168.50
Permanent acrylic denture (per denture)	£ 281.75
Permanent metal denture (per denture)	£ 355.00
Temporary denture following tooth loss (per denture)	£ 122.75
Laboratory made temporary bridge following tooth loss (three units)	£ 78.75
Additional unit to bridge	£ 20.50
Any other necessary treatment (per incident)	£ 350.00

The limit under this section is £5000 per incident subject to the individual maximum reimbursements shown and 2 incidents per policy period

**DENTAL ACCIDENT AND EMERGENCY COVER
BENEFIT SCHEDULE**

Section 1-Emergency Treatment

The purpose of this section is to provide cover for emergency treatment in the UK when you are unable to receive treatment from your own dentist. The section will cover temporary treatment required to alleviate dental pain or discomfort. The cover is not available for any subsequent permanent or routine treatment.

	Maximum Reimbursement
Examination and treatment of sensitivity	£ 23.50
X-Rays (per incident)	£ 18.00
Tooth Extraction (per tooth-maximum of 2 teeth per incident)	£ 31.00
Root extirpation including dressing and treatment of infection (1 canal)	£ 41.25
Root extirpation including dressing and treatment of infection (2 canals)	£ 46.25
Root extirpation including dressing and treatment of infection (3 canals)	£ 59.50
Treatment of infection including prescriptions	£ 17.75
Investigation and dressing (for 1st tooth)	£ 18.25
Investigation and dressing (for each additional tooth)	£ 12.50
Re-cement crown or inlay (per tooth)	£ 20.50
Re-cement bridge	£ 26.25
Provision and fitting of temporary crown (per tooth)	£ 39.25
Provision and fitting of temporary post and core (per tooth)	£ 19.50
Provision and fitting of temporary bridge (per bridge)	£ 72.00
Treatment to stop haemorrhage including aftercare and removal of sutures	£ 27.25
Removal of sutures inserted by another practitioner	£ 16.00
Repair/adjust orthodontic appliance (per incident)	£ 36.50
Denture adjustment (per incident)	£ 15.00
Repair of denture to include re-fixing of teeth and gums and repair clasp (per incident)	£ 30.75
Any other temporary emergency treatment (per incident)	£ 42.25

The limit under this section is £325 per incident and £650 per policy period subject to the individual maximum reimbursements shown. The insured is responsible for the first £10 of any denture-related claim.

Section 2-Emergency Consultation

If you suffer a dental emergency in the UK and require advice by telephone from or to call out any dentist at a time when their surgery is normally closed you may claim the actual cost of one or other of the following items up to the amount shown.

	Maximum Reimbursement
Telephone consultation only (per incident)	
6am-10pm	£ 23.50
10pm-6am	£ 36.00
Call out fees (per incident)	
6am-8am and 8pm-10pm	£ 90.50
8am-8pm Weekends and Bank Holidays	£ 90.50
10pm-6am	£162.00

The insured is responsible for the first £15 of any call out fee. Cover is limited to two domiciliary visits in any one policy year.