BERT Dental Claim Form

Please return this completed form to:

Email: claims@bert.com.au | **Fax:** 07 3832 3799 | **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 ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Given name Date of birth D D M M Y Y Y Y

Street address

Suburb State Postcode

Postal address (Write 'AS ABOVE' if same as Street address)

Suburb State Postcode

Telephone Home Mobile

Email address

BERT Member No. (if known) Union CFMEU ☐ CEPU ☐ Union No. (if known)

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 BSB Number –

Account Name Account Number

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

CLAIMANT DETAILS

Surname ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Given names Date of birth D D M M Y Y Y Y

Relationship to Member ☐ Member ☐ Spouse ☐ Defacto ☐ Child ☐ Dependant Child

EMPLOYMENT DETAILS

Trading Name of Employer

Street address

Suburb State Postcode

ACCIDENT DETAILS

Give the exact date and time the accident occurred D D M M Y Y Y Y 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 Technician who provided them to you.

Where did the accident occur? Home Work Other (give details)

Address where the accident occurred.

Name of any witnesses to the accident

Address of witness

Suburb State Postcode

Name of 2nd witness to the accident

Address of 2nd witness

Suburb State Postcode

Did the accident occur while training or playing sport? Yes No If yes, name of club?

Please provide the date you first received treatment for this incident, together details for the dentist who treated you

Date first treated D D M M Y Y Y Y Name of Dentist

Dentists Address

Suburb Phone

Please provide the name, address and phone of any dentist who treat you prior to the accident

Name of Dentist

Address

Suburb Phone

PRIVATE HEALTH INSURANCE DETAILS

Do you have Private Health Insurance? Yes No If yes, name of your Health Insurer

Does you Private Health Insurer Include Dental Cover? Yes No

PLEASE NOTE: It is a condition of the BERT Dental Scheme that you lodge all dental claims with your private dental insurer first

Have you lodged a claim with your Private Health Insurer for this claim? Yes No If yes, please attach a copy of all rebate slips

AUTHORISATION OF CLAIMANT (If you are under the age of 18, a guardian is to sign authority)

I hereby authorise any dentist, employer or any other person relevant, to supply BERT Administrators with any information including all current and prior history relevant to this claim. I agree that a photocopy of this authorisation form 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 beign forfeited.

Signature of Claimant ✕ Date D D M M Y Y Y Y

MEMBER DECLARATION

I hereby authorise my union to supply BERT with details of my union payments to assist with eligibility to claim.

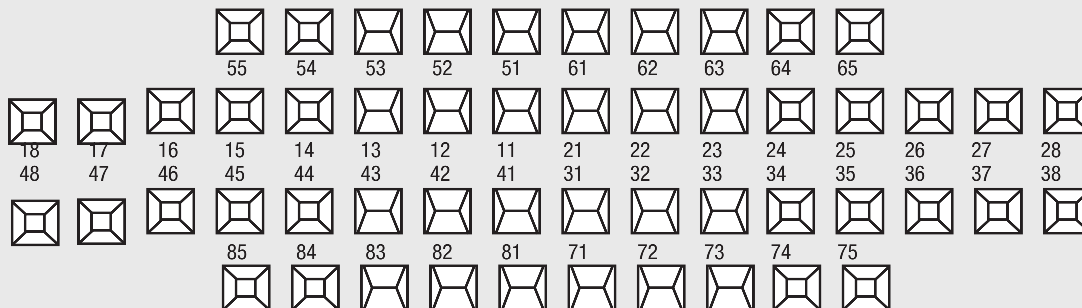
Signature of Member ✕ Date D D M M Y Y Y Y

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 comlete 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. Please advise if only the tooth



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? ☐

Was the damaged tooth/teeth sound and health prior to the accident? ☐ 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? D D M M Y Y Y Y

What did the patient tell you, as to 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' regular dentist? ☐ Yes ☐ No

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

If yes, please advise the name of the Heatlh 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 D D M M Y Y Y Y

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 health 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 finanical member of the above Union(s) at the time of the incident.

- 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 liqour 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

Member Number ☐☐☐☐☐☐☐☐

CFMEU QLD/NT