

Please send claim form to:  
Chartis Europe S.A.  
Kalvebod Brygge 45  
DK-1560 København V  
Tlf +45 33 73 24 00  
Fax +45 33 73 24 70  
[www.chartisinsurance.com](http://www.chartisinsurance.com)



## Claim Form - Dental Accident

It is important that you complete this form in as much detail as possible. If this claim form has been completed correctly we will be able to settle the claim faster.

Your dentist must complete the dental form.

If you have any questions regarding your claim or how to complete this form please do not hesitate to contact our claims department.

Best regards,  
**Chartis Europe S.A.**

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Claims no.  
(Filled in by Chartis)



## Claim Form – Dental Accident

### POLICY HOLDER

CVR no.	Policy no.
Name of company	Contact person
Address	ZIP code and City

### INSURED

Job title	CPR -no.
Name	Bank registration and account no.:
Address	ZIP Code, city
Telephone no. daytime /cellular phone no.	E-mail

### OTHER INSURANCE, WORKERS COMPENSATION INSURANCE, ACCIDENT INSURANCE

Has the accident been reported to other insurance companies?  Yes  No

If yes, which?

Company	Type of Insurance	Police no./claim no.

Are you a member of Health Insurance Denmark?  Yes  No

If yes, which group (1, 2, 5, or 8)?

## DESCRIPTION OF THE ACCIDENT

When did the accident occur?	Date	Time
Where did the accident take place? Please write address		
At work	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
During leisure time	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
During voluntary work	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
How did the accident occur? <u>(It is important that the event is described thoroughly)</u>		
How did the accident happen?		
Were you under the influence of alcohol or any other intoxicating substances when the accident occurred? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Was the accident reported to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to what department?	

## SIGNATURE

I hereby declare that the information I have specified in this claim form is the truth. I am aware that false information or any suppressions may cause a reduction in the compensation or that no compensation is payable.

Chartis may obtain medical information from medical physicians, medical institutions, insurance companies and public authorities that may contribute to a correct assessment of my condition and that Chartis may inform these of the information that I have given Chartis.

If the accident has been reported to the police or the Workers Compensation Board I hereby give Chartis permission to obtain information from them.

Date: \_\_\_\_\_

\_\_\_\_\_

Employer's signature  
(Only if the insurance has been paid by the employer)

\_\_\_\_\_

Signature

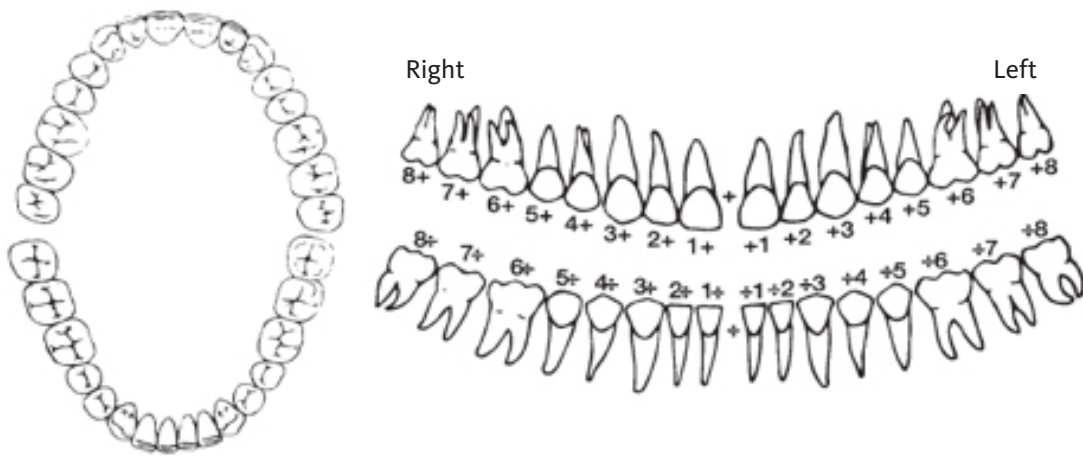
## DENTAL FORM – TO BE COMPLETED BY THE DENTIST

Date of the accident
What date did the insured take contact to you for the first time in connection to this accident?
What did the insured inform you about the accident?
Has the insured been treated by another dentist or at the ER? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>
If yes, what kind of treatment was done and by who?
_____ dated x-rays enclosed (will be returned) Claims are only handled without x-rays as an exception.

**INFORMATION ABOUT THE INJURED TEETH ( SEE LIST OF DIAGNOSIS BELOW)**

Which teeth	Diagnosis, letter	Tilstand før skaden							
		Intact	Carieret Surface	Filling, surface Material	Crown		Paradontitis		
					Type	Material	Apikalis	Marginalis	

In case of tooth or root fracture, please draw the fracture line on the schedule below



Condition of the other teetths (further remarks can be given below)

- Frequently dental care   
  Well-kept   
  Neglected   
  Carierede   
  Paradontitis   
  Bad mouth hygiene

Other relevant information

**INFORMATION IN CONNECTION WITH DAMAGE TO DENTURES**

Type and extend of the injury/damage			
Bodily injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Denture type <input type="checkbox"/> Whole <input type="checkbox"/> Partial	Age of the denture	Material
Which teeth is the denture replacing?		Pre-existing defects or damage	

**SUGGESTED TREATMENT**

Acute /temporary treatment	Fee minus health insurance in DKK
Final treatment	

l alt 

Is final treatment possible at the moment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Period of observation recommended
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Possible permanent effects

Are you the patient's usual dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by public child or youth dental care programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental Damage on children and teenagers: The insurance is secondary therefore continuous check ups and treatment will take place via the public dental care program until the insured is 18 years old

Name of the dentist	<b>Stamp and phone no.</b>
Address	
ZIP code/City	
Date and signature	
SE/CVR no. of the recipient of the fee	
Bank registration and account no.	

This claim form must be mailed to Chartis. The insurer is not liable to pay compensation until the it has accepted the claim and approved the suggested treatment.

This dental report will be paid by Chartis pursuant to the agreement between the Danish Insurance society and the dentist society. The wording of this form has been agreed with the dentist society.

# List of the most common occurring traumadiagnosis

After Andressen 1972

Infractis clentis (A)

Fractura coronae dentis noncomplicata (B,C)

Fractura coronae dentis complicata (D)

Fractura coronae et radices dentis non complicata (E)

Fractura coronae et radices dentis complicata

Fractura radices dentis (G)

Fractura processus alveolaris

Fractura corporis mandibulae

Fractura corporis maxillae

Concussio dentis (H)

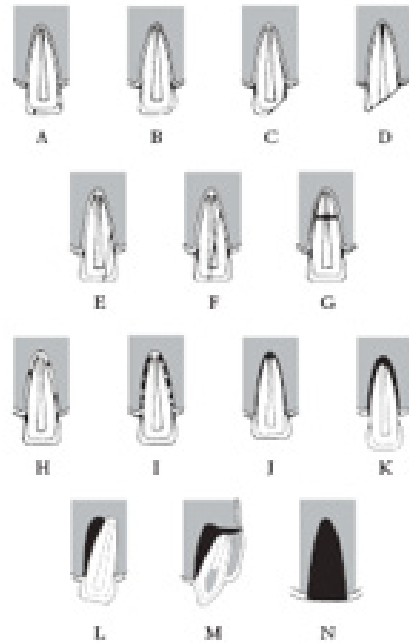
Subluxatio dentis (I)

Intrusio dentis (J)

Extrusio dentis (K)

Luxatio lateralis dentis (L, M)

Exarticulatio dentis (N)



Other relevant information