Please send claim form to:

anmeldelse@aig.com

AIG Europe S.A.
Bryggernes Plads 2
DK-1799 København V
TLF +45 91 37 53 00

www.aig.dk

Claim Form - Dental Accident

It is important that you complete this form in as much detail as possible. The more precise the answers to our questions are the sooner we will be able to respond to this form.

If the accident has caused personal injury and there is a medical report from the emergency room please submit it along with this 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
AIG Europe S.A.

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Claim Form – Dental Accident

POLICY HOLDER

Company name	Policy no.
Address	
ZIP code	City

INSURED

Job title	CPR -no.
Name	Bank registration and account no.:
Address	ZIP Code, city
Telephone no. daytime /cellular phone	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 og 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	☐ Yes	☐ No
During leisure time	☐ Yes	☐ No
During voluntary work	☐ Yes	☐ No

How did the accident occur? (It is important that the event is described thoroughly)

How did the accident happen?

Were you under the influence of alcohol or any other intoxicating substances when the accident occurred? ☐ Yes ☐ No

Was the accident reported to the police?	☐ Yes ☐ 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	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?

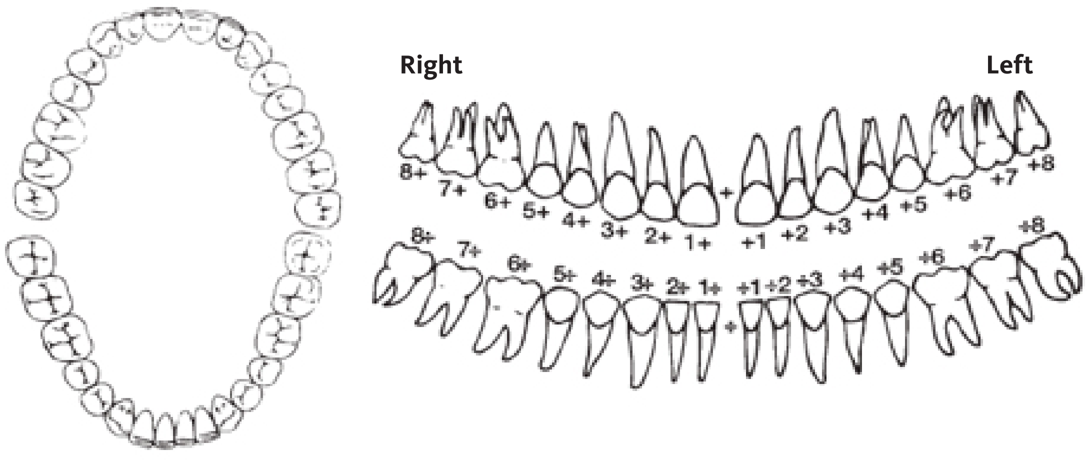
Has the insured been treated by another dentist or at the ER? ☐ Yes ☐ No
If yes, what kind of treatment was done and by who?

_______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	Condition before injury							
		Intact	Carieret	Filling, surface	Crown		Root canal	Paradontitis	
			Surface	Material	Type	Material	treatment	Apikalis	Marginalis

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



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

☐ Frequenly 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	Denture type	Age of the denture	Material
☐ Yes ☐ No	☐ Whole ☐ Partial		

Which teeth is the denture replacing?	Pre-existing defects or damage

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

Total ▶

Is final treatment possible at the moment? ☐ Yes ☐ No	Period of observation recommended

Possible permanent effects

Are you the patient's usual dentist? ☐ Yes ☐ No	Covered by public child or youth dental care programs? ☐ Yes ☐ No

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

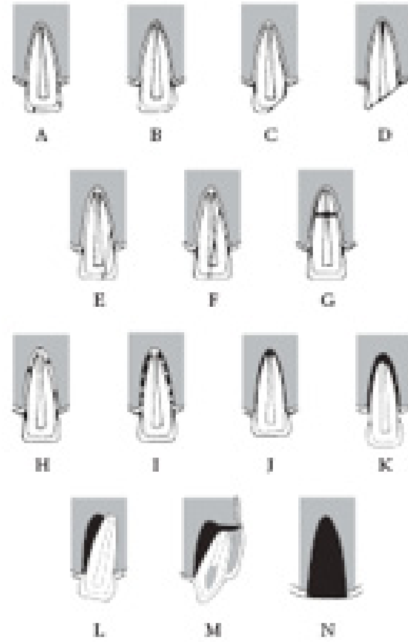
Name of the dentist	Stamp and phone no.
Address	
ZIP code/City	
Date and signature	
SE/CVR no. of the recipient of the fee	
Bank registration and account no.	

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 radicis dentis non complicata (E)
Fractura coronae et radicis dentis complicata

Fractura radicis dentis (G)
Fractura processus alveolaris
Fractura corpuris mandibulae
Fractura corpuris maxilae

Conncussio dentis (H)
Subluxatio dentis (I)
Intrusio dentis (J)
Extrusio dentis (K)

Luxatio lateralis dentis (L, M)
Exarticulatio dentis (N)

Other relevant information