zestlife
Cover you can trust.
People you can depend on.

RETURN ADDRESS AND ZESTLIFE CONTACT DETAILS:
E-mail: info@zestlife.co.za
Fax: 021 180 4375
Post: PostNet Suite #87, Private Bag X1005, Claremont, 7735
Tel: 021 180 4220 / 0860 009 378
Web: www.zestlife.co.za

Claim Form

Dental Cover

1. POLICYHOLDER DETAILS

Title | Full names

Surname

Date of birth (DD/MM/YYYY) | Identity number

Dental Cover policy number

Cell phone number | Telephone number

Address | Postal code

E-mail address

DECLARATION BY POLICYHOLDER AND PERMISSION TO SHARE INFORMATION WITH A THIRD PARTY

I declare that the above information is true, that I have withheld no material information and that all relevant documentation is attached to this claim form.

I authorise my medical aid, hospital, medical practitioner, dental practitioner or other person who has attended to me or lives insured by my policy, or examined me or lives insured by my policy, to furnish to Zestlife, Denis Insurance Administrators (Pty) Ltd or Guardrisk any information with respect to any illness or injury, medical history consultation, prescriptions or treatment and copies of all hospital or medical records. Such information could relate to medical information (i.e. claims transaction history, hospital procedures, health records etc.)

I further authorise Zestlife, Denis Insurance Administrators (Pty) Ltd and Guardrisk or their authorised representative to share any information obtained as referred to above with my appointed Dental Cover Financial Advisor.

Signature of policyholder or appointed executor if policyholder is deceased _____ DD/MM/YYYY

2. POLICYHOLDER BANK ACCOUNT DETAILS

Please provide the bank details of the **policyholder**. The benefit cannot be paid into a business bank account or to a third party.

Full first names of account holder

Surname of account holder

Identity number of accountholder

Bank name

Branch name | Branch Code

Account number | Account type

Signed at _____ on this _____ day of _____ 20 _____

Signature of account holder _____

3. INSURED PERSON DETAILS

Title | Full names

Surname

Date of birth DD/MM/YYYY Identity number (Compulsory)

Relation to policyholder Self ☐ Spouse ☐ Child ☐

4. CLAIM EVENT DETAILS

4.1 Was the claim due to an accident? Yes ☐ No ☐

If yes, please provide:

Date of accident DD/MM/YYYY

Details of accident

4.2 Has the insured person been covered for less than 12 months by the policy? Yes ☐ No ☐

If yes, please provide:

When did the condition leading to the claim occur? DD/MM/YYYY

Date of first consultation with a dentist/specialist for this condition DD/MM/YYYY

Name and contact details of dentists/specialists

	Name	Telephone number
Usual dentist		
Treating dentist/specialist		
Dentist/specialist who made the diagnosis		

4.3 Details of dentist/specialist providing quote/invoice for claim procedure

Name

Address

Practice number Date of visit DD/MM/YYYY

4.4 Benefit you are claiming for

Benefit	Claim event	Comprehensive Dental payout	Core Dental payout	Superior Dental payout	Smart Dental payout	Mark with X
Dental treatment	General Dental Event	R 900	R 600	R 1 000	R 800	☐
	Gingivitis	Not covered	Not covered	R 500	R 400	☐
	Tooth Decay (good prognosis) - filling	Not covered	Not covered	R 500	R 400	☐
	Tooth Decay (poor prognosis) - extraction	Not covered	Not covered	R 1 000	R 800	☐
	Periodontitis	Not covered	Not covered	R 1 800	R 1 600	☐
	Chipped Tooth	Refer to Accident benefit	Refer to Accident benefit	R 500	R 400	☐
	Severely Decayed or Damaged Tooth or tooth damaged by an abscess	R 1 200	R 600	R 5 000	Not covered	☐
	Impacted Wisdom Tooth	R 1 800	R 900	R 2 500	R 2 000	☐
Emergency	Dental Abscess	R 3 000	R 1 200	R 2 500	R 2 000	☐
	Dental Emergency	R 3 000	R 1 200	R 2 500	R 2 000	☐
Accident	Chipped Tooth	R 1 200	R 600	Refer to Dental Treatment	Refer to Dental Treatment	☐
	Fractured Tooth	R 6 000	R 2 400	R 5 000	R 2 500	☐
	Knocked Tooth Loose/Out	R 6 000	R 2 400	R10 000	R 5 000	☐
	Jaw Fracture	R30 000	R18 000	R30 000	R25 000	☐

Benefit	Claim event	Comprehensive Dental payout	Core Dental payout	Superior Dental payout	Smart Dental payout	Mark with X
Oral Cancer	Oral Cancer	R30 000	R18 000	R30 000	R25 000	☐
Long-term treatment	Dentures	R 6 600	Not covered	R 2 500	R 2 000	☐
	Dental Implants	R12 000	Not covered	R12 000	Not covered	☐
	Dental Bridges	R12 000	Not covered	R12 000	Not covered	☐

Documents to attach to the claim form:

1. Dentist quote or invoice for the procedure. ☐
2. Dentist X-rays and/or diagnostic report for applicable teeth affected. ☐
3. If an oral cancer claim, then also provide a copy of the related medical and histology reports. ☐
4. If also due to an accident, then also provide dentist motivation of accidental injury and tooth number. ☐

Processing of your claim cannot start until we have this completed claim form and all the listed documents. You must notify us of a claim within six months of the claim incident date.

5. PROCESSING OF PERSONAL INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT 4 OF 2013

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of any benefit payable;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
4. Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent.

You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.