Allianz Care

# Dental Questionnaire

If you choose to complete a printed version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS**.

First name

Surname

Date of birth D D / M M / Y Y Y Y

**1. Are dental measures (bridges, crowns, inlays, onlays, implants, etc.) currently being performed or recommended?** Yes ☐ No ☐

If Yes, please provide details

Expected cost (incl. currency)

*Please attach a treatment/cost plan.*

**2. Do you suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)?** Yes ☐ No ☐

If Yes, please provide details

Details of ongoing treatment

Details of planned treatment

Expected cost (incl. currency)

*Please attach a treatment/cost plan.*

**3. Dental chart**

Please fill in the dental chart below using the abbreviations provided. For your information, the first front tooth on your upper left jaw is referred to as number 21; number 22 is the tooth located to the left of this.

### Abbreviations

Currently existing:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| m | = | missing tooth | b | = | bridge | | |
| g | = | gap closure | i | = | implant | | |
| c | = | crown | in | = | inlay | | |
| f | = | filling | on | = | onlay | | |

Planned treatment/procedure:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| I | = | Implant | B | = | Bridge | | |
| C | = | Crown | S | = | Support element | | |
| T | = | Telescope crown | IN | = | Inlay | | |
| ON | = | Onlay | M | = | Metal-ceramic crown | | |

| Right | | | | | | | | | Left | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatment date (MM/YY) | | | | | | | | | | | | | | | | | Treatment date (MM/YY) |
| Planned treatment | | | | | | | | | | | | | | | | | Planned treatment |
| Existing | | | | | | | | | | | | | | | | | Existing |
| Upper jaw | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | Upper jaw |
| Lower jaw | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | Lower jaw |
| Existing | | | | | | | | | | | | | | | | | Existing |
| Planned treatment | | | | | | | | | | | | | | | | | Planned treatment |
| Treatment date (MM/YY) | | | | | | | | | | | | | | | | | Treatment date (MM/YY) |

### Example

If you already have an existing crown, the letter "c" must be entered into the "**Existing**" row (located above or below the number) and in the box that relates to this tooth. Similarly, if an implant is planned, an "I" must be entered into the relevant box on the "**Planned treatment**" row.

## Your personal data

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**

Alternatively, you can contact us on **+ 353 1 630 1301** to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: **AWC.DataPrivacyOfficer@allianz.com**

## Declaration

Please read the following declarations carefully and only sign below if you understand and accept them.

(a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Care and myself, and that any false, incorrect or misleading statement or non-disclosure of material medical information may make this insurance null and void.

**(b) I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Dental Questionnaire and the start date of the policy.**

(c) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and in the context of this application for insurance. I consent to allow Allianz Care, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare providers all statements concerning previous or existing contracts I may have applied for.

(d) Subject to legal restrictions, Allianz Care (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities and medical facilities to provide relevant medical information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.

This declaration and form must be signed and dated by the applicant presenting the dental condition(s). If the applicant is a minor, a parent or guardian should sign this section.

Signature _____ Date D D / M M / Y Y Y Y

Printed name

## Please return your fully completed questionnaire by:

**Email to:** underwriting@e.allianz.com

**Post to:** Underwriting Team
Allianz Partners
15 Joyce Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

If you have any questions regarding this Dental Questionnaire, please contact our Helpline on: + 353 1 630 1301 or email: underwriting@e.allianz.com

FRM-DQ-EN-1023