Aevitae
Confidential/Medical confidentiality/PBZ
Postbus 2705
6401 Heerlen
medisch-geheim@aevitae.com for the attention of the department Polisbeheer Zorg

Dental insurance questionnaire

Regarding the application for dental insurance, please fill in this form fully for each insured party and send it signed to the address above or scan it and send it by email.

Personal details

Initials: Surname:

Street name / number:

Post code / town:

Date of birth: __ __ - __ __ - __ __ __ __

Telephone number: Email address:

Contract number

or application number:

Preferred dental insurance:

1 Does the person to be insured, if 8 years or older, expect to receive orthodontic treatment within two years or is he/she already under treatment?

- ○ Yes
- ○ No

(Note: this is a general questionnaire. Orthodontics is not always covered in the supplemental dental insurance. In the coverage overview can you see which reimbursements are included in the package.)

2 Has the person to be insured, if 18 years or older, been for an annual check up at the dentist in the past two years?

- ○ Yes
- ○ No

3 Does the person to be insured, if 18 years or older, have a congenital dental abnormality?

- ○ Yes
- ○ No

If yes, which dental abnormality does this concern?

4 **Has the person to be insured, if 18 years or older, ever had 4 or more teeth or molars removed (excl. wisdom teeth) or are these missing naturally?**

- ○ Yes
- ○ No

If yes, how many teeth have been replaced?

5 **Does the person to be insured, if 18 years or older, expect one or more of the following treatments within two years? Or has the person to be insured started with one or more treatments for:**

- ○ Yes. 4 or more fillings or 4 or more old fillings to be replaced
- ○ Yes. One or more crowns.
- ○ Yes. One or more bridges.
- ○ Yes. One or more implants.
- ○ Yes. A partial dental prosthesis (plate or frame).
- ○ Yes. An extensive gum treatment.
- ○ Yes. 2 or more root canal treatments.
- ○ No

Important!

After assessment of the examination report you will receive a reply from us.
If the requested effective date is permissible according to the policy conditions and the application has been submitted in time, the dental insurance will be added as of the requested effective date.

Signature

We reserve the right to verify the information specified by you with your dentist.

I declare that I have answered the questions truthfully and I am aware of the conditions. I know that filling in this form incorrectly/incomplete or concealing facts that are of interest to the insurance(s) may lead to limitation or invalidation of the right to benefits. If I intentionally mislead Aevitae, Aevitae reserves the right to terminate the insurance.

Date: __ __ - __ __ - __ __ __ __ Signature of policy holder: