

STANDARD DENTAL CLAIM FORM Please print

CANADIAN DENTAL ASSOCIATION



DAI	T 4	DE	NITI	O.T.							.0000 p		UNIC	QUE N	1O.		SPE	C.	PAT	Ψ™ IENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS		
PARI 1 DENTISI													D								PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE		
<u>A</u> _			AIVIE GIVEN IVAIVIE													PAYMENT DIRECTLY TO THE							
Ι ′	ADDRESS APT. T																						
	CITY PROV. POSTAL CODE										ODE	<u> </u>											
T FOR												OSIS.	T PHONE NO. SIGNATURE OF SUBSCRIBER I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY										
PROCEDURES, OR SPECIAL CONSIDERATION.													PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.										
													I AC	ACKNOWLEDGE THAT THE TOTAL FEE OF \$									
													I AL	JTHOI	RIZE I	RELE	ASE	OF T	THE IN	FORMATION CONTAINED IN	THIS CLAIM FORM TO MY INSURING		
													TO T	THE C	OVER	AGE	OF S	ERVI	CES DI	ESCRIBED IN THIS FORM TO T	UNICATION OF INFORMATION RELATED HE NAMED DENTIST.		
														IGNATURE OF PATIENT (PARENT/GUARDIAN) FFICE VERIFICATION									
BOLLIOATE FOLIM [OFF										
	OF SE	RVICE YR.	1	PROCEDU CODE				OOTH	TH TOOTH	DENTIST'S FEE		6	LABORATORY CHARGE			TOTAL CHARGES					STRUCTIONS		
			T																	the student. We may e	 All claims under this group benefits plan are submitted through the student. We may exchange personal information about 		
					\top	\top							\top			Н			\Box	when necessary to confi	and a person acting on their behalf rm eligibility and to mutually manage		
			T			\top										Н				the claims.1. Have your dentist con	nplete Part 1.		
			T		\Box	\top							\dashv			П	\Box		\Box	 Student completes Pa If you wish benefits to 	be paid directly to the dentist, sign the		
																П				assignment portion of	Part 1 above. Assignment of benefits a Life may discuss details of this claim		
																П				with the assignee. 4. Send this claim to:			
													T			П					oll Free: 1.800.957.9777		
																				Winnipeg Benefit Pay			
																Ш				PO Box 3050 Station Winnipeg MB R3C 0			
																Ш				www.canadalife.com	f hearing and require access		
to a tele									to a telecomm	nunications relay service? et us: TTY to Voice: 711													
AND	THE T	OTAL	JKA FEE	DU	E ANI	D PAY	ABLE,	E. & O.	E.	MED TO	OTAL I	FEE S	SUE	ЗМІТ	TED						1-800-855-0511		
							MATI																
																				Student Identification Num	nber		
Plan Name																							
Student Name Date of birth / / / Student address Day Month Year																							
	ıdeni													_									
At cla	Cana im a	ada L nd a	_ife dm	, WE	rec	ogn a th	ize ar e aroi	nd res un be	pect the	import in Foi	tance o r a con	of priv	acy	. Pei Priva	rsona acv G	d inf Juid	orm eline	ation	that	we collect will be used for u have questions about (r the purposes of assessing your our personal information policies		
an	d pra	ctice	es (i	ncl	udin	g wi	th res	pect 1	to service	provi	ders), v	write	to C	Cana	da Li	fe's	Chi	ef Co	ompli	ance Officer or refer to w	ww.canadalife.com.		
l al	so c	onse	nt t	o th	e us	se of	f my p	erso	nal inform	nation	for Ca	ınada	Life	e an	d its a	affili	ates	' inte	rnal o	data management and ar	nalytics purposes.		
Ιa	utho	rize	Cai	nad	a Li	fe, a	any h	ealtho	care prov	vider, r	my pla	n adı	mini	istra	tor, o	the	r ins	uran	ce o	r reinsurance companies	s, administrators of government		
																					or outside Canada, to exchange disclosure to those authorized		
																				ect, and complete to the			
Student's Signature PART 3 COORDINATION OF BENEFITS																			Dat	ie			
						•	-													2. Patient's date of	f birth///		
									atient res						_	_					Day Month feat		
4.	If the	e chi	ld i	S 0\	er 1		•		ependent														
									it, how m														
_							,				-					-			-	ours worked per week?			
5.	,	-			-				•	-						-				⊥ Yes ∟ No			
Name of other insurance company Policy Number																							
b) Is any member of your family (other than yourself) insured as a Student under this plan? Yc) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Da																							
																ase	prov	/iae s	spous	se's Date of Birth —— /- Day	Month Year		
б.	Is this treatment required as the result of an accident? Yes No No No Nonth Year If yes, give date, location, and explain how accident happened																						
7	•				-		-		olain now s Compe					_	es	Π,	NI^						
				_														lf no	aivo	date of prior placement	and reason for replacement.		
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