

STANDARD DENTAL CLAIM FORM Please print

CANADIAN DENTAL ASSOCIATION



| DAI | T 4 | DE | NITI | O.T. | | | | | | | .0000 p | 1 | UNIQ | UE N | О. | | SPE | C. | PA | ♥™ TIENT'S OFFICE ACCOUNT NO | I HEREBY ASSIGN MY BENEFITS | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------|--------------|---------------|--------|---------------|-----------------|------------------|------------------------|------------------|--------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------|-----------------|--------------|----------------|---------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| P LAST NAME GIVEN NAME D | | | | | | | | | | | | | D | | | | | | | | PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE | | | |
| <u>A</u> _ | | | | | | | | | | | PAYMENT DIRECTLY TO THE DENTIS | | | | | | | | | | | | | |
| Ι ′ | ADDRE | ESS | | | | | | | | | , | | Ť | | | | | | | | | | | |
| | | | | | | | | | | | | | <u> </u> | | | | | | | | | | | |
| T FOR | FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, | | | | | | | | | | | | T PHONE NO. SIGNATURE OF SUBSCRIBER 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. | | | | | | | | | | | |
| | | | | | | | | | | | | - [1 | I ACK | ACKNOWLEDGE THAT THE TOTAL FEE OF \$ | | | | | | | | | | |
| | | | | | | | | | | | | - [1 | AU | THOF | RIZE F | RELE | ASE | OF T | ГНЕ І | NFORMATION CONTAINED IN | THIS CLAIM FORM TO MY INSURING | | | |
| | | | | | | | | | | | | - | то т | HE C | OVER | AGE | OF S | ERVI | CES D | ESCRIBED IN THIS FORM TO | IUNICATION OF INFORMATION RELATED THE NAMED DENTIST. | | | |
| | | | | | | | | | | | | | | | | | | (PAR | ENT/G | GUARDIAN) | | | | |
| DUP | LICAT | E FO | RM | | | | | | | | | | OFFI | CE VI | ERIFIC | CATIC | ON | | | | | | | |
| | OF SE | RVICE YR. | F | | CEDU | IRE | INTL.TOOTH | | TOOTH SURFACES | DENTIST'S FEE | | | LABORATORY CHARGE | | | TOTAL CHARGES | | | | | ISTRUCTIONS | | | |
| | - | | | | | | 1 1 | | 1211111020 | | | | | | | | | | | the student. We may | All claims under this group benefits plan are submitted through the student. We may exchange personal information about | | | |
| | + | | | | \top | | + | | | | | | \top | | T | \forall | \top | \top | H | when necessary to con | claims with the student and a person acting on their behalf when necessary to confirm eligibility and to mutually manage | | | |
| | | | T | | | | | | | | | | | | | \Box | \top | | | the claims. 1. Have your dentist co | mplete Part 1. | | | |
| | | | T | | \neg | | | | | | | | \top | | | H | | | | If you wish benefits to | 2. Student completes Parts 2 and 3. 3. If you wish benefits to be paid directly to the dentist, sign the | | | |
| | | | | | | | | | | | | | | | | | | | | assignment portion of is irrevocable. Canad | assignment portion of Part 1 above. Assignment of benefits is irrevocable. Canada Life may discuss details of this claim | | | |
| | | | | | | | | | | | | | | | | | | | | with the assignee. 4. Send this claim to: | , | | | |
| | | | | | | | | | | | | | | | | | | | | | Toll Free: 1.800.957.9777 | | | |
| | | | | | | | | | | | | | | | | | | | | Winnipeg Benefit Pa | yments | | | |
| | | | | | | | | | | | | | | | | | | | | PO Box 3050 Statio Winnipeg MB R3C | | | | |
| | | | | | | | | | | | | | | | | | | | | www.canadalife.com | of hearing and require access | | | |
| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE SUBMITTED TOTAL FEE SUBMITTED TOTAL FEE SUBMITTED TOTAL FEE SUBMITTED | | | | | | | | | | | | nunications relay service? | | | | | | | | | | | | |
| AND | THE T | OTAL | FEE | DU | E ANE | PAY | ABLE, | E. & O. | E. | TC | OTAL F | EE S | SUB | МІТ | TED | | | | | | 1-800-855-0511 | | | |
| | | | | | | | MATI | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | Student Identification Nu | mber | | | |
| Plan Name | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Name Date of birth / / / / Par | | | | | | | | | | | | | | | | | | | | | | | | |
| | ıdent | | | | | | | | | | | | | _ | | | | | | | | | | |
| At cla | Cana im a | ada l nd a | _ite; dmi | , WE inisi | rec | ogni a the | ze ar e aroi | nd res Jip be | pect the nefits pla | mporta n. For | ance of | t priva | acy. our F | . Per Priva | sona cv G | al int Auide | orm eline | atior es. o | that if vo | t we collect will be used to ou have questions about | or the purposes of assessing your our personal information policies | | | |
| an | d pra | ctice | es (i | ncli | udin | g wit | h res | pect t | to service | provid | ders), v | vrite | to C | ana | da Li | fe's | Chi | ef Co | ompl | iance Officer or refer to <u>v</u> | ww.canadalife.com. | | | |
| I al | so c | onse | nt t | o th | e us | e of | my p | erso | nal inform | nation f | for Ca | nada | Life | e and | d its a | affili | ates | ' inte | rnal | data management and a | nalytics purposes. | | | |
| Ιa | utho | rize | Car | nad | a Li | fe, a | ny h | ealtho | care prov | rider, n | ny plar | n adr | nini | strat | or, o | the | rins | urar | ice o | or reinsurance companie | s, administrators of government | | | |
| | | | | | | | | | | | | | | | | | | | | | or outside Canada, to exchange o disclosure to those authorized | | | |
| | | | | | | | | | | | | | | | | | | | | rect, and complete to the | | | | |
| 04. | | , O | · | . 4 | | | | | | | | | | | | | | | | D | | | | |
| | Ideni | | _ | | | ON (|)E BI | ENEF | TS | | | | | | | | | | | Da | ite | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | • | - | | | | | | | | | | | | | 2. Patient's date of | of birth/ | | | |
| | | | | | | | | | atient res | | | | _ | _ | _ | ٦ | | | | | bay Monai roa | | | |
| 4. | If the | e chi | ld is | S 0\ | er 1 | | | | ependent | | | | | | | | | | | | | | | |
| | | | | | | | | | nt, how m | | | _ | _ | | | | | | | | | | | |
| E | ۵) ، | ١ | | ~ . | | | , | | | | - | | | | | - | | | | hours worked per week? | | | | |
| Э. | , | - | | | - | | | | • | - | | | | | | - | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of other insurance company Policy Number b) Is any member of your family (other than yourself) insured as a Student under this plan? | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | 1 | | | | | | | | | | | | | |
| | ls this treatment required as the result of an accident? \square Yes \square No | | | | | | | | | | | | | | | | | | | | | | | |
| J. | | | | | | • | | | lain how | | | | | | | | | | | | | | | |
| 7 | • | | | | | | - | | s Compe | | | • | _ | _ | 'es | | Vn | | | | | | | |
| | | | | _ | | | | | | | | | _ | | | | | lf no | , give | e date of prior placement | and reason for replacement. | | | |
| | | | | | | | | | | | | | | | | | | | | , p | | | | |