

STANDARD DENTAL CLAIM FORM

Canadian
Dental
Association

Canadian Life and Health Insurance Association	

Please print													ASSOCIATION							Insurance Association		
PART 1 DENTIST UNIQUE													IIQUI	UE NO. SPEC. PATIENT'S OFFICE ACCOUNT NO						NT'S	OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED
P	LAS	AST NAME GIVEN NAME D DENTIST AND AUTHORIZE PAY													DENTIST AND AUTHORIZE PAYMENT							
Т	ADE	RES	RESS APT. T												DATE OF TO THIS PLET.							
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T	Cii	1					PH	OV.	PUS 17	AL CI	ODE	S	PI	HONE	NO.							SIGNATURE OF SUBSCRIBER
									NFORMATION, D	IAGN	IOSIS	S, I UN	NDEF	RSTAN	TAHT OF	THE F	EES	LIS	ED	IN T	THIS CLAIM MAY NOT BE	COVERED BY OR MAY EXCEED MY PLAN.
	PROCEDURES, OR SPECIAL CONSIDERATION. BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMEN' I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN CHARGED TO MI FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLA ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST. DUPLICATE FORM SIGNATURE OF PATIENT (PARENT/GUARDIAN)																					
DU	PLIC	ATE F	ORM									OFF	FICE	VERI	FICATION	1					SIGNA	TUHE OF PATIENT (PARENT/GUARDIAN)
DATE OF SERVICE PROCEDURE INTL.TOOTH TOOTH DENTIST													ST'S LABORATORY TOTAL							Business and part	INSTRUCTIONS	
DAY	MO.	YR.			ODE		\bot	CODE	SURFACES	Ļ ,		EE						RGE	s	_	All claims under this	group benefits plan are submitted
_	_	-	⊢	\vdash	Н	\dashv	+	-		╂┼	+	++		+	++-	${\mathbb H}$	╁	$\left \cdot \right $	+	\dashv	l through the plan mer	mber. We may exchange personal ims with the plan member and a
	 	\vdash	╁╌	-	Н	\dashv	+	+		H	+	++	\dashv	+	++-	\vdash	+	Н	+	ᅥ	person acting on his	or her behalf when necessary to
								工		П	\perp	\Box					\top	П	\top	╗	1. Have your dentist	to mutually manage the claims.
						\Box		\Box		П	\perp	\prod				\Box	I	Ц	\perp		2. Employee comple	tes Parts 2 and 3. is to be paid directly to the dentist, sign
		├	⊢	<u> </u>	Н	\dashv	+	+		H	\dashv	+		+	₩.	H	\bot	Н	+	4	I the assignment po	ortion of Part 1 above. Assignment of
	\vdash	-	\vdash	\vdash	Н	\rightarrow	+	+		H	+	++	\dashv	+	++-	H	+	H	+	-	details of this clair	able. Great-West Life may discuss m with the assignee.
	<u> </u>	\vdash	T			1	\top			H	\top	11	7	\top	\vdash	H	+	H	+	\dashv	4. Send this claim to	: <u> </u>
													\Box								Regina Benefit Pa P.O. Box 4408	· · · · · · · · · · · · · · · · · · ·
		-	<u> </u>	ļ			+	+		\sqcup	1	++	4	+	+	Н	\perp		\downarrow		Regina SK S4P : English: 1-866-28	3W7 9-5675
THIS	HIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED ND THE TOTAL FEE SUBMITTED																					
								ATION		'`	JIA	L FE	ES	UBN	מפוווובט						Toll Free: 1-800-9	90-6654 Phone: (204) 946-7281
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																		npl	oye	e I	dentification No	
	Plan Name																					
Er	Employee name Date of birth/ _/																					
	•	-																				
At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.																						
Er	nplo	yee'	s Si	igna	itur	e															Date	e
PA	ABT	3 C(OOF	DIN	IAT	ON	OF E	BENEF	ITS		-						_				·	
PART 3 COORDINATION OF BENEFITS 1. Patient's relationship to you																						
		•							patient resid			•										
4.	If th	ne cl	nild	is o	ver	18:	•		he a full-time												•	
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5.	,		•		-				-	-							-		•		? ☐ Yes ☐ No	
		If ye	s, n	am	e of	fan	nily n	nembe	er insured									_	_ F	Rela	ationship to employ	/ee
		Nan	ne o	f ot	her	insı	urano	e com	pany		_								_ F	Poli	icy number	
	b)	ls a	ny n	nem	ıbeı	of	your	family	(other than	you	rse	lf) ins	ure	ed as	an en	plog	yee	un	der	thi	s plan? 🗌 Yes 🛭	□ No
	c)	If ye	s to	qu	esti	ons	5 a)	or b),	and the pati	ent	is a	dep	enc	dent	child, p	oleas	se p	rov	ide	sp	ouse's Date of Birt	h/
6.	Day Month 3. Is this treatment required as the result of an accident? Yes No If yes, give date, location, and explain how accident happened																					
7.	ls a	a cla	im t	ein	g m	ade	for '	Worke	r's Compens	atic	on E	 Benef	its?)	☐ Yes		No					
ĺ					-				-										no,	giv	ve date of prior plac	cement and reason for replacement