

## STANDARD DENTAL CLAIM FORM





				_							P	lease pr	int								₩ m		
PA	RT 1	DE	NT	IST									UN	IQUI	E NO.		SPE	C.	P	PATIEN	NT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE	
												NAME	D			NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST							
T ADDRESS												APT	N	N									
1													T	i									
														S SIGNATURE OF SUBSCRIBER SIGNATURE OF SUBSCRIBER									
FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, I											NOSIS,	ΙU	UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE										
PROCEDURES, OR SPECIAL CONSIDERATION.													TR	TREATMENT.									
													I A	I ACKNOWLEDGE THAT THE TOTAL FEE OF \$IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.									
																						THIS CLAIM FORM TO MY INSURING IUNICATION OF INFORMATION RELATED	
													то	THE	COVER	RAGE	OF	SERVI	CES	DES	CRIBED IN THIS FORM TO T		
													-					(PAR	ENT	r/GUAI	RDIAN)		
BOT EIGHTE TOTIM EI													Ог	OFFICE VERIFICATION									
	OF S	ERVICE YR.	4		CED	URE E		L.TOOTH CODE	TOOTH SURFACES				LABORATORY CHARGE			TOTAL CHARGES				GES		STRUCTIONS	
			T	Т		Ī															the plan member. We	up benefits plan are submitted through may exchange personal information	
	+					Н				$\vdash$	+								$\vdash$		on their behalf when n	plan member and a person acting ecessary to confirm eligibility and to	
	+		$^{+}$			Н				$\vdash$	+						$\Box$		+		mutually manage the cla 1. Have your dentist cor	mplete Part 1.	
	+		+	$\vdash$		$\vdash$				$\vdash$	+					+	$\Box$	+	+		Employee completes     If you wish benefits to	Parts 2 and 3. be paid directly to the dentist, sign the	
	+					$\vdash$				$\vdash$	+					+	$\Box$	+			<ul> <li>assignment portion of</li> </ul>	f Part 1 above. Assignment of benefits a Life may discuss details of this claim	
	+		+	+		$\vdash$				$\vdash$	+					+	$\Box$	+	+		with the assignee.	a Life may discuss details of this claim	
	+		+	$\vdash$		$\vdash$				$\vdash$	+					+	$\Box$	+	+		4. Send this claim to:		
	+		+			H				H	+					+	Н		t		Questions? Call 1	Toll Free:	
	+		+	$\vdash$		H				$\vdash$	+					+	$\Box$	+	+		†		
	+		+			H				$\vdash$	+					+	Н	+	+		1		
-	+		$^{+}$			H				H	+					+	$\Box$		t		www.canadalife.com  Deaf or hard of	hearing and require access	
									<u> </u> :ES PERFORN	MED _											to a telecommu	unications relay service? us: TTY to Voice: 711 -800-855-0511	
								E, E. & (			IOIA	LFEE	50	BIV	IITTED						Voice to TTY: 1-	-800-855-0511	
								ATION												_			
		umbe																				umber	
Plan Name  Date of birth																							
Employee Name Date of birth / / Employee address																							
					_		nizo	and ro	encet the i	mno	rtana	of pri		., C	Porcon	al in	forn	nation	ı th	ot w	a collect will be used for	or the purposes of assessing your	
cla	aim a	and a	dm	inis	teri	na t	he ar	d quo	enefits pla	n. Fo	or a c	o vac	our	Pr	ivacv (	Guic	delin	es. o	r if	vou l	have questions about	our personal information policies	
ar	d pr	actice	es (	incl	udii	ng v	vith re	espect	to service	prov	/iders	), write	to	Ca	nada L	ife's	s Ch	ief C	om	plian	ce Officer or refer to w	ww.canadalife.com.	
Ιa	ılso d	conse	ent	to th	ne u	ıse	of my	perso	onal inform	atior	n for (	Canad	a Li	ife a	and its	affil	liate	s' inte	erna	al dat	ta management and a	nalytics purposes.	
Į a	autho	orize	Ca	nad	a L	_ife,	any	health	care prov	ider,	my p	olan ad	lmiı	nist	rator, o	othe	r in	surar	nce	or r	einsurance companie	s, administrators of government	
l be	enetii	is or (	otne forr	er b nati	ene on	efits wh	prog en ne	rams, ecessa	other orga arv for the	ınıza se nı	itions, urnos	orser	VICE	e pr erst	ovider	S Wo	orkii Sers	າg wr ວກal	tn ( info	Jana orma	ida Life, located within tion may be subject to	or outside Canada, to exchange disclosure to those authorized	
ur	der	appli	cab	le la	aw	with	nin or	outsio	de Canada	a. I c	ertify	that the	e in	for	mation	giv	en i	s true	e, c	orrec	ct, and complete to the	e best of my knowledge.	
Er	nplo	vee's	Sid	nat	ure	·															Da	te	
P/	ART :	3 CC	OOF	RDII	TA/	101	N OF	BENE	FITS														
1.	Pat	ient's	re	latic	nsl	hip 1	to you	ı													2. Patient's date o		
3.	If th	ne pa	tier	ıt is	a c	hild	l, doe	s the	oatient res	ide v	vith yo	ou? 🗌	Ye	s	☐ No							Day Month Year	
4.	If th	ne chi	ild i	s ov	/er	18:	a) Is	the d	lependent	a ful	l-time	studer	nt?		Yes		No						
							b) If	stude	nt, how ma	any I	nours	per we	ek	at :	school'	?					_		
							c) Is	the d	ependent	empl	loyed'	? 🗌 Ye	es		No I	f ye	s, h	ow m	any	y hou	urs worked per week?		
5.	a)	Are y	/ou	or a	any	oth															Yes No		
		If yes	s, n	ame	e of	f far	nily m	nembe	r insured _										_	Rela	tionship to employee _		
																					n? Yes No		
	,		-				-	-	•	-	,					-					s Date of Birth/		
6.									esult of an								•				Day	Month Year	
									plain how														
7.	•				-		-		's Comper						Yes		No						
									•						_			If no	, gi	ve da	ate of prior placement	and reason for replacement.	
						,			- '										-		•	·	