

STANDARD DENTAL CLAIM FORM





Please print													Please i	orint	nt 3							ASSOCIATION		
																IIQUE	E NO.		SI	PEC.		PATIE	NT'S OFFICE ACCOUNT NO.	
	LAST NAME GIVEN NAME DE													EN NAM										
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E N T	CIT	Y		PROV. POSTAL CODE S												PHONE NO. SIGNATURE OF SUBSCRIBER								
FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS,											AGNOSIS	S, I U	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY											
· · · · · · · · · · · · · · · · · · ·														TR	PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.									
															I A	ACKNOWLEDGE THAT THE TOTAL FEE OF \$IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.								
															I A	AUTH	IORIZ	ZE RI	ELEAS	SE O	FΤ	HE INFO	ORMATION CONTAINED IN	THIS CLAIM FORM TO MY INSURING UNICATION OF INFORMATION RELATED
															ТО) THE	E CON	/ERA	GE OI	= SEF	RVIC	ES DES	CRIBED IN THIS FORM TO T	HE NAMED DENTIST.
														SIC	SIGNATURE OF PATIENT (PARENT/GUARDIAN)									
														OF										
DATE OF SERVICE PROCEDURE INTLTOOTH TOOTH DENTIST'S DAY MO. YR. CODE CODE SURFACES FEE														LA	LABORATORY CHARGE TOTAL CHARGES								STRUCTIONS	
Dire		10.		╈	Τ	T		Τ	+		JOIN ACLO							-					All claims under this grout the plan member. We	p benefits plan are submitted through may exchange personal information
_	+			+	+	+	-	+					+					-	+			_	about claims with the	plan member and a person acting ecessary to confirm eligibility and to
-	+			+	+	+	+	+	-	_		\vdash	+						+			_	mutually manage the cla 1. Have your dentist con	ims.
_	+			+	+	+	+	╈	-				-					-		+		_	2. Employee completes	Parts 2 and 3.
-	+			+	+	+		+	-				-		-			_					assignment portion of	be paid directly to the dentist, sign the Part 1 above. Assignment of benefits
⊢	+			+	+	+		╋	-			\vdash	-					-					with the assignee.	a Life may discuss details of this claim
⊢	+			+	+	+		╋	-				-					_	-			_	4. Send this claim to:	
-	-			+	+	+		+	-				+		_			-	+			_	Questions? Call 1	oll Free:
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\vdash	+			+	+	+	-	+	-				-					_	-				-	
	-			+	+	+	-	+					-					_	-				www.canadalife.com	hearing and require access
THI	S IS	AN	ACCI	UR/	ATE :	STA		EN [®]	T OF S	SERVIC	ES PERFORI	MED											to a telecommu Please contact u	nications relay service? Is: TTY to Voice: 711
AND THE TOTAL FEE DOE AND PATABLE, E. & O.E. TOTAL FEE SOBIVITIED VOICE to TTY: 1-800-855-0511																								
PART 2 EMPLOYEE INFORMATION																								
Plan Number Division Number Employee Identification Number																								
	Employee Name Date of birth / / / / / / _ / _ / _ / _ / _ / _ / _																							
cl	At Canada 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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to <u>www.canadalife.com</u> .																							
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benefits or other benefits programs, other organizations, or service providers working with Canada Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized																								
under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.																								
Employee's Signature Date																								
Ρ/	AR1	٦3	C	00	RDI	INA	TIC	N	OF E	BENE	FITS													
																							2. Patient's date of	
3.	lf	the	pa	tie	nt is	s a	chil	ld,	does	s the	patient res	ide v	with	you?	Ye	s [N	lo						Day Month Year
4.	lf	the	ch	ild	is c	ve	r 18	3:	a) Is	the c	lependent	a fu	ll-tim	ne stude	ent?		Yes		No					
									b) If	stude	ent, how m	any	hou	rs per v	veek	ats	scho	ol?					_	
									c) Is	the d	lependent	emp	oloye	ed? 🗌 `	Yes		No	lf y	yes,	how	ma	ny hou	urs worked per week? .	
5.	5. a) Are you or any other member of your family entitled to benefits under any other plan? Yes No																							
		lf	yes	s, r	nam	ne o	of fa	ami	ily m	embe	r insured											Rela	tionship to employee _	
		Ν	lam	ec	of of	the	r in	sur	ance	e com	ipany											Polic	y Number	
	b)) Is	s an	ıy r	ner	nbe	er o	f yo	our f	amily	(other tha	n yo	urse	lf) insu	red a	as a	n er	nplo	yee	unde	er th	nis plar	n? 🗌 Yes 🗌 No	
	C)	lf	yes	s to	o qu	ies	tion	s 5	5 a) d	or b),	and the pa	atien	it is a	a deper	nden	t ch	ild, j	plea	se pi	ovid	le s	pouse	's Date of Birth /_	
6.	6. Is this treatment required as the result of an accident? Yes No													Month Year										
If yes, give date, location, and explain how accident happened																								
7. Is a claim being made for Worker's Compensation Benefits?																								
8. If claim is for denture, crown or bridge, is this initial placement? 🗌 Yes 🗌 No If no, give date of prior placement and reason for replacement.																								
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