

PART 1 DENTIST
UNIQUE NO. SPEC. PATIENT'S OFFICE ACCOUNT NO.
I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST.
P LAST NAME GIVEN NAME
ADDRESS APT.
CITY PROV. POSTAL CODE
DENTIST PHONE NO.
SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.
I 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 TREATMENT.
I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.
SIGNATURE OF PATIENT (PARENT/GUARDIAN)
OFFICE VERIFICATION

Table with columns: DATE OF SERVICE (DAY, MO., YR.), PROCEDURE CODE, INTL. TOOTH CODE, TOOTH SURFACES, DENTIST'S FEE, LABORATORY CHARGE, TOTAL CHARGES. Includes INSTRUCTIONS section with a list of 4 steps and contact information for questions.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E. TOTAL FEE SUBMITTED

PART 2 STUDENT INFORMATION

Plan Number Division Number Student Identification Number
Plan Name
Student Name Date of birth
Student address

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 www.canadalife.com.
I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.
I authorize Canada 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 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.
Student's Signature Date

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you 2. Patient's date of birth
3. If the patient is a child, does the patient reside with you?
4. If the child is over 18: a) Is the dependent a full-time student? b) If student, how many hours per week at school? c) Is the dependent employed?
5. a) Are you or any other member of your family entitled to benefits under any other plan? b) Is any member of your family (other than yourself) insured as a Student under this plan? c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth
6. Is this treatment required as the result of an accident?
7. Is a claim being made for Worker's Compensation Benefits?
8. If claim is for denture, crown or bridge, is this initial placement?