

## 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													
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													<u> </u>											
<b>T</b> 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	<ul> <li>All claims under this group benefits plan are submitted through the student. We may exchange personal information about</li> </ul>			
	+				$\top$		+						$\top$		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				<ol><li>If you wish benefits to</li></ol>	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			
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4.	If the	e chi	ld is	S 0\	er 1				ependent															
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Name of other insurance company Policy Number b) Is any member of your family (other than yourself) insured as a Student under this plan?																								
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	ls this treatment required as the result of an accident? $\square$ Yes $\square$ No																							
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7	•						-		s Compe			•	_	_	'es		Vn							
				_									_					lf no	, give	e date of prior placement	and reason for replacement.			
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