

STANDARD DENTAL CLAIM FORM





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PA	RT	1	DEI	NTI	ѕт										U	NIQ	UEI	NO.		SPE	C.		PATIEN	NT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE	
														VEN NAI		D NAMED DENTIST AND AUTHORIZE E PAYMENT DIRECTLY TO THE DENTIST.										
A T	ADDRESS AFT. T															N										
E	CITY	Y PROV. POSTAL CODE S																								
Т															Ť	PHONE NO. SIGNATURE OF SUBSCRIBER										
	PROCEDURES, OR SPECIAL CONSIDERATION.															UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY CLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE										
															L	REATMENT. ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN ;HARGED TO ME FOR SERVICES RENDERED.										
															C	HAR AUT	ige Tho	D TO N RIZE F	/IE FO RELE	OR S EASE	ERV	CES TH	REND	DERED. ORMATION CONTAINED IN	THIS CLAIM FORM TO MY INSURING	
																	DMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED D THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.									
																	GNATURE OF PATIENT (PARENT/GUARDIAN)									
															0											
		DF SERVICE PROCEDURE INTL.TOOTH TOOTH DENTIST'S MO. YR. CODE CODE SURFACES FEE										l			ATORY RGE	т	OTAL CHARGES					STRUCTIONS				
							_					\square	Ť	TT				T						the student. We may e	up benefits plan are submitted through exchange personal information about	
												Ħ	+	++			╈	+			+			when necessary to conf	and a person acting on their behalf irm eligibility and to mutually manage	
																								the claims. 1. Have your dentist cor	nplete Part 1.	
																									be paid directly to the dentist, sign the	
																								is irrevocable. Canada	Part 1 above. Assignment of benefits a Life may discuss details of this claim	
									<u> </u>	<u> </u>	<u> </u>	\square	\perp	++										with the assignee.4. Send this claim to:		
										_	<u> </u>	\vdash	+	++	\rightarrow		_	—			_			Questions? Call 1	oll Free: 1.800.957.9777	
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⊢	+	+								┼──		\vdash	+	++	+	-	+	+	-		+	-		Deaf or hard o	f hearing and require access	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED										t us: TTY to Voice: 711																
	AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E. TOTAL FEE SUBMITTED Voice to TTY: 1-800-855-0511 PART 2 STUDENT INFORMATION																									
	Plan Number Division Number Student Identification Number																									
	Plan Name																									
	Student Name Date of birth																									
St	Student address Day Month Year																									
At	Ca	nac	da L	ife	we	re	coc	gniz	e ar	nd re	spect the i	mpo	ortar	nce of	priva	icy.	Pe	rsona	al int	form	natic	n th	nat we	e collect will be used fo	r the purposes of assessing your	
ar	aim 1d p	and rac	a ao tice	s (i	ncl	udi	ng v ng v	tne with	groi res ו	up be pect	to service	.n.⊢ ∍prc	∙or a ovid∈	i copy ers), w	or ou rite to	ur P ca	ana	acy C ada Li	ife's	cin Ch	es, (ief (or II Con	you plian	nave questions about about about the officer or refer to with the officer or refer to with the other terms about terms about the other terms about t	our personal information policies ww.canadalife.com.	
la	and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to <u>www.canadalife.com</u> . I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.																									
																									s, 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 o	f birth / / Day Month Year	
											patient res lependent					_	-	_								
4.		ne	Crin	u i	5 01	/ei	10.		,		nt, how m															
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5.	c) Is the dependent employed? Yes No If yes, how many hours worked per week? 5. a) Are you or any other member of your family entitled to benefits under any other plan? Yes No																									
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	b)	ls	any	/ m	em	beı	r of	yoı	ur fa	mily	(other that	n yc	urse	əlf) ins	ured	as	a S	Studer	nt u	nde	r thi	s pl	an?	Yes No		
					•				,		•			•					ase	pro	vide	e sp	ouse'	's Date of Birth /-		
6. Is this treatment required as the result of an accident? Yes No Day Month Year																										
If yes, give date, location, and explain how accident happened																										
 Is a claim being made for Worker's Compensation Benefits? Yes No 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. 																										
8.	lf (claii	m is	s fo	r de	ent	ure,	, cro	own	or bi	ridge, is th	ns ir	nitial	place	ment	?∟	`	Yes		No	lf n	o, g	live da	ate of prior placement	and reason for replacement.	

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