THE Great-West Life ASSURANCE COMPANY

# STANDARD DENTAL CLAIM FORM

*Please print*

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association

## 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 HIM/HER.

SIGNATURE OF SUBSCRIBER

**PATIENT**

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

**DENTIST**

PHONE NO.

FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

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

| DATE OF SERVICE DAY | MO. | YR. | PROCEDURE CODE | INTL TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES |
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THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.

**TOTAL FEE SUBMITTED**

### INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

**London Benefit Payments**
**255 Dufferin Avenue**
**London ON N6A 4K1**
**Toll Free: 1-800-263-5742 Or: (519) 435-6903**

**For the deaf or hard of hearing:**
**Toll Free: 1-800-990-6654**
**Or: (204) 946-7281**

## PART 2 EMPLOYEE INFORMATION

Plan Number_____ Division Number_____ Employee Identification Number _____

Plan Name _____

Employee Name _____ Date of birth ____ / ____ / ____ (Day / Month / Year)

Employee address _____

At Great-West 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. I authorize Great-West 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 Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

**DO YOU WANT ANY UNPAID PORTION OF YOUR CLAIM PROCESSED THROUGH YOUR HEALTHCARE SPENDING ACCOUNT? ☐ YES ☐ NO**

**IF CLAIMING FOR REIMBURSEMENT FROM THE HEALTHCARE SPENDING ACCOUNT, ARE YOU ENTITLED TO CLAIM A MEDICAL EXPENSE TAX CREDIT UNDER THE INCOME TAX ACT (CANADA) FOR THE PATIENT? ☐ YES ☐ NO**

## PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you _____ 2. Patient's date of birth ____ / ____ / ____ (Day / Month / Year)
3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
4. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school?_____
   c) Is he/she 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
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy Number _____
   b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____ / ____ / ____ (Day / Month / Year)
6. Is this treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, give date, location, and explain how accident happened _____
7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
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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