STANDARD DENTAL CLAIM FORM

Canadian Dental Association

DENTAL PLAN FOR UNIONIZED EMPLOYEES OF CANADIAN PACIFIC

ADMINISTERED BY THE GREAT-WEST LIFE ASSURANCE COMPANY

GROUP PLAN NO. 51078

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.

SIGNATURE OF PATIENT (PARENT GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

INSTRUCTIONS TO CLAIMANT

1. COMPLETE EMPLOYEE STATEMENT (PART 2)
2. HAVE YOUR DENTIST COMPLETE PART 1.
3. SEND THIS FORM TO GREAT-WEST, BENEFIT PAYMENTS OFFICE AT THE APPROPRIATE ADDRESS LISTED BELOW.
4. THE CLAIM CHEQUE WILL BE SENT DIRECTLY TO YOU, OR TO YOUR DENTIST IF YOU HAVE COMPLETED THE ASSIGNMENT SECTION IN PART 1.

BENEFIT PAYMENTS OFFICE FOR CLAIMANT'S RESIDENT IN:

QUEBEC:

The Great-West Life Assurance Co.
Montreal Benefit Payment Office
P.O. Box 400, 40 Dolbeau
Place Bonaventure
Montreal, Quebec
H5A 1B9

ALL OTHER PROVINCES:

The Great-West Life Assurance Co.
Health and Dental Claims Centre
P.O. Box 6030, Station Main
Winnipeg, Manitoba
R3C 3C8

PART 2 EMPLOYEE STATEMENT

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

PLEASE PRINT

1. NAME OF EMPLOYEE
   (LAST NAME) _____
   (FIRST NAME) _____
2. EMPLOYEE NO. _____
   SOCIAL INSURANCE NUMBER _____
3. ADDRESS _____
4. IF CLAIM FOR DEPENDENT, NAME OF PATIENT _____
   (A) DATE OF BIRTH ___|___|___ (DAY MONTH YEAR) RELATIONSHIP _____
   (B) IF CHILD AGE 21 OR OVER INDICATE
   ☐ FULL-TIME STUDENT ☐ HANDICAPPED
   (C) IF STUDENT INDICATE SCHOOL _____
   (D) EMPLOYED ☐ YES ☐ NO IF YES, FULL-TIME ☐ PART-TIME ☐
5. A) ARE YOU OR ANY OTHER MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS FROM ANY OTHER SOURCE? YES ☐ NO ☐
   IF YES, GIVE NAME AND ADDRESS OF OTHER SOURCE
   _____
   NAME OF FAMILY MEMBER INSURED _____
   POLICY # _____
   B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? YES ☐ NO ☐
   IF YES, NAME OF FAMILY MEMBER _____
   C) IF YES TO A) OR B) ABOVE, AND THE PATIENT IS A DEPENDENT CHILD, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ___|___ (DATE DAY MONTH)
6. (A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT?
   ☐ YES ☐ NO
   GIVE DATE AND DETAILS _____
   (B) IS CLAIM BEING MADE FOR WORKMEN'S COMPENSATION BENEFITS?
   ☐ YES ☐ NO
7. IF CLAIM FOR DENTURES, CROWN OR BRIDGE, IS THIS INTIAL PLACEMENT?
   ☐ YES ☐ NO
   IF NO, GIVE DATE OF PRIOR REPLACEMENT AND REASON FOR REPLACEMENT.
   DATE _____ REASON _____

I HEREBY AUTHORIZE THE USE OF MY SOCIAL INSURANCE NUMBER AS AN IDENTIFICATION NUMBER WHERE IT IS REQUIRED IN THE ADMINISTRATION OF BENEFITS UNDER MY GREAT-WEST LIFE GROUP COVERAGE(S). I AUTHORIZE RELEASE OF ANY INFORMATION OR RECORD REQUESTED IN RESPECT OF THIS CLAIM TO GREAT-WEST LIFE OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF EMPLOYEE

DATE ___|___|___ (DAY MONTH YEAR)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL