

## STANDARD DENTAL CLAIM FORM



Canadian Life and Health Insurance Association

										F	'leas	e pi	rint									V™	Insurance Association	
P	٩RT	1 D	EN	TIST	Г								UNIC	QUE NO	).	S	PEC.		PA	TIENT	Γ'S	S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST	
P LAST NAME GIVEN NAME										D	AND AUTHORIZE PAY							AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.						
A T	ADE	ADDRESS APT.											E N											
E	CITY PROV. POSTAL CODE									_	T													
E N T	CIT	ſ					F	ROV		POSTA	AL COL	JΕ	S	PHONI	E NO.								SIGNATURE OF SUBSCRIBER	
FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION,											I UNI										BE COVERED BY OR MAY EXCEED MY PLAN			
													I ACŁ	BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. ACKNOWLEDGE THAT THE TOTAL FEE OF \$										
														SERVIC				E IN	FOF	RMAT	IO	ON CONTAINED IN THIS C	LAIM FORM TO MY INSURING COMPANY/PLAN	
																						COMMUNICATION OF INF HE NAMED DENTIST.	ORMATION RELATED TO THE COVERAGE OF	
				_									1	IATURE										
DU	PLIC	ATE F	ORI	и 🗀									OFFI	CE VER	RIFICA	TION								
DATE OF SERVICE PROCEDURE INTL.TOOTH TOOTH DENTIS												FNTI	ST'S LABORATORY TOTAL						ΆΙ		1		INSTRUCTIONS	
	MO.			CODE				CC	DDE	SURFACES	با	FEI		CHARGE			CHARG			3	4	All claims under this group benefits plan are submitted through		
			╀	-	-	-					$\vdash$	-		+	+			+	+	-			may exchange personal information about nember and a person acting on his or her	
			+								H	+		+	+			+	+		┪	behalf when necessa	ary to confirm eligibility and to mutually	
			t								H			+	$\top$			$\dashv$	$^{\dagger}$			manage the claims.  1. Have your dentist of	complete Part 1	
																					٦	2. Employee complete	es Parts 2 and 3.	
											Ш			$\perp \! \! \perp$	Ш				_		4		to be paid directly to the dentist, sign the of Part 1 above. Assignment of benefits is	
			+	-		-						-		+	+			4	+		4	irrevocable. Great-	West Life may discuss details of this claim	
			+								H	+		+	+			+	+		┨	with the assignee. 4. Send this claim to:		
			t								H			+	$\top$			$\dashv$	$^{\dagger}$		┨	Questions? Call 1	Toll Free: 1.800.957.9777	
																					1	Winnipeg Benefit	Payments	
TLUC	10.4	1.00		1	<u> </u>		VIT OF	050	), ((OFC	S PERFORMED	Ш										4	P.O. Box 3050 Winnipeg MB R3		
AND	THE	TOT	AL F	EE D	UE /	AND I	PAYA	BLE,	E. & C	D.E.	TO	ΓAL	FEE	SUBI	MITT	ΓED					╝		or hard of hearing: 800.990.6654	
									ION												Į			
PI	an N	lo					511	89		Di	visio	n N	0					Em	plo	yee	e lo	dentification No		
Plan Name I.B.E.W. LU. 353 WELFARE PLAN																								
Er	Employee Name Date of birth//																							
Er	nplo	yee	ad	dres	SS _																		used for the purposes of assessing	
yo	ur cl	aim	and	l adı	min	ister	ing t	he g	roup	benefits plan	. For	a co	o ygc	four F	riva	cy G	uideli	nes	, OI	r if yo	วน	ı have questions abo	out our personal information policies	
an	d pr	actic	es	(incl	ludi Wo	ng w	vith r	esp	ect to	service prov	iders	), W	rite to	o Grea	at-We	est L	ife's	Chie	ef (	Com	pli	liance Officer or refe	r to <u>www.greatwestlife.com</u> . nies, administrators of government	
be	nefi	sor	oth	er b	ene	efitsi	oróa	ram	s. oth	ner orgʻanizati	ońs.	ors	ervic	e prov	iders	ow' a	kina	with	ı Gı	reat-	٠٧	Vest Life, located wit	hin or outside Canada, to exchange	
pe	rsor der	ıaı ii ann	ntor lica	mat ble l	ion aw	whe	en n nin ດ	ece:	ssary tside	/ for these pu Canada. I ce	urpos ertify	es. that	I und t the	dersta inform	ınd t natioi	nat p n aiv	oerso ven is	nai tru	int e. c	corre	at ec	tion may be subject and complete to t	t 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.  Employee's Signature																							
FOR ACTIVE MEMBERS ONLY:																								
DO YOU WANT ANY UNPAID PORTION OF YOUR CLAIM PROCESSED THROUGH YOUR HEALTHCARE SPENDING ACCOUNT?   IF CLAIMING FOR REIMBURSEMENT FROM THE HEALTHCARE SPENDING ACCOUNT, ARE YOU ENTITLED TO CLAIM A MEDICAL EXPENSE																								
TΑ	X C	RED	DIT	UNI	DEF	R TH	IE IN	1CO	ME	TAX ACT (CA	NAI	DA)	FOR	THE	PAT	IEN	Γ?			YES	3	□ NO		
P	ART	3 C	00	RDI	NA	1017	N OF	BE	NEF	ITS														
1.	Pat	ient	's r	elat	ions	ship	to y	ou .														2. Patient's [	Date of Birth: / Month /_Year	
3.	If th	ne p	atie	ent i	s a	chil	d, d	oes	the	patient reside	e wit	h yo	ou?	□ Ye	s L	J No	)						,	
4.	If th	ie c	hild	is (	ove	r 18	,			he a full-time														
											-		-											
																-				-			ek?	
5.			-			-				-	-						-					? ☐ Yes ☐ No		
																							/ee	
										-												-		
																						s plan?		
_	C)	ıt ye	es t	o qu	ies.	แดกร	s 5 a	a) OI	r D),	and the patie	ent is	a	aepe	ndent	cnil	a, pl	ease	pro	OVI	ae s	p	ouse's Date of Birt	Day / Month	
6.	ıs t	nis t	rea	ıme	ent	requ	ııred	as	tne i	resuit of an a	ICCID	ent'	<i>!</i> 🗀	res	⊔ <b>ľ</b>	ОИ	іт уе	s, g	JIVE	e da	ιte	e, location, and exp	plain how accident happened	
7	_ lo 6	مام	im	hoi-	nc -	mad	o fo	r \//	orko	r'e Compone	ation	Pa	nofit	c2		/00		<u> </u>						
					_					r's Compens									lf ∽	. ~	ii.	o data of prior plac	cement and reason for replacement	
Ο.	II C	aiiii	15	iOi (	u <del>c</del> i i	uie	, UI	וועע	טו ט	nage, is tills	ıı IILlic	ıι ΙΙ	auti	nent?	ĭ	62	□ 1	U	11 11	o, y	ı۷	e uate of hill higo	ement and reason for replacement	