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STANDARD DENTAL CLAIM FORM

Please print

3sHealth better together

L'ASSOCIATION DENTAIRE CANADIENNE

CLHIA ACCAP

PART 1 DENTIST

Please see reverse for details on how to file your claim.

PATIENT

Last name | First name

Address | Apt.

City | Prov. | Postal Code

DENTIST

Unique no. | Spec. | Patient's office account no.

Phone no.

I hereby assign my benefits payable from this claim to the named dentist and authorize payments directly to the dentist.

Signature of subscriber

For dentist use only — For additional information, diagnosis, procedures, or special consideration

Duplicate form ☐

Office verification / Dentist's signature

Date of service Day Month Year	Procedure code	Intl. tooth code	Tooth surfaces	Dentist's fee	Laboratory charge	Total charge

This is an accurate statement of services performed and the total fee due and payable. E&OE

TOTAL FEE SUBMITTED

Was pre-authorization obtained for these procedures?

☐ Yes ☐ No

Is any treatment for orthodontic purposes?

☐ Yes ☐ No

If yes, attach a copy of the treatment plan.

PART 2 EMPLOYEE STATEMENT

It is suggested that any treatment exceeding $500.00 should be approved by the Insurer before it begins

Group Contract number **335663** | Benefit ID | Employer

Employee Last Name | First Name

Employee's Address (Street, City, Province, Postal Code)

PART 3 CO-ORDINATION 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 the patient a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Are they employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____
   d) Are they mentally or physically challenged? ☐ Yes ☐ No
5. a) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   b) 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 _____
   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

PLEASE SIGN THE AUTHORIZATION SECTION

At Canada 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. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I authorize Canada 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 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.

Plan Member's Signature _____ Date _____

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HOW TO CLAIM DENTAL INSURANCE BENEFITS

Electronic Dental Claim Submission / EDI:

Many Dental offices can accommodate Electronic Dental Claim Submission. Your Dental office will require you to provide your Group Contract Number and Certificate Number to complete the electronic transaction.

Ask your Dental office for more details.

Paper Claim Submission:

1 Take this form to your dentist and have them complete the dentist's statement on the reverse side of this form.

2 Complete the employee statement and questionnaire. Please be sure you fully answer all questions.

3 Please sign and date the authorization section.

4 Under the co-ordination of benefits provision, if your spouse has coverage under another insurance plan, your spouse's charges must first be submitted under that plan. Charges for dependent children should first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year

5 Mail the completed form directly to the claims office indicated below.

REMINDER

Proof of claim must be submitted within 120 days following the earlier of your termination of employment or the end of the calendar year in which the expense is incurred. Claims submitted after the deadline will not be considered for payment.

This form must be completed in full. Incomplete forms will be returned to you, which will delay the processing of the claim.

MAIL THE COMPLETED FORM DIRECTLY TO THE CLAIMS OFFICE INDICATED BELOW

Questions? Call Toll Free: 1.866.408.0213

Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7
www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us: TTY to Voice: 711 Voice to TTY: 1-800-855-0511

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