THE Great-West Life ASSURANCE COMPANY

OUT-OF-SCOPE MEMBERS STANDARD DENTAL EXPENSES HEALTHCARE SPENDING ACCOUNT CLAIM FORM

3sHealth — CANADIAN DENTAL ASSOCIATION — CLHIA ACCAP

Please print

IMPORTANT: Lifestyles Spending Account expenses must be submitted to 3sHealth.

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

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. Plan Member 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:

Questions? Call Toll Free: 1.866.408.0213

Regina Benefit Payments
PO Box 4408
Regina SK S4P 3W7

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

PART 2 PLAN MEMBER INFORMATION

Plan Number **335663** Benefit ID _______________

Plan Name **HEALTH SHARED SERVICES SASKATCHEWAN (3sHEALTH)**

Plan Member Name _______________ Date of birth ____/_____/_____ (Day Month Year)

Plan Member 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. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

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, 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 _______________

PART 3 COORDINATION OF BENEFITS

Benefit payments from the HSA should be coordinated with the benefits provided by your other dental coverage to provide up to a maximum of 100% of coverage. To maximize the benefits of your HSA, submit expenses first to your dental plan, and if you have additional dental coverage through a spouse's plan, submit your expenses to that plan next. Then submit your expenses to your HSA for reimbursement. Remember, you can use the HSA account to cover expenses for you and your eligible dependents.

1. **Benefits are to be paid from:** ☐ **Dental Plan** ☐ **HCSA** ☐ **Both**
2. If claiming for reimbursement from the HCSA Account, are you entitled to claim a medical expense tax credit under the income Tax Act (Canada) for the patient? ☐ Yes ☐ No

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? _______________

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PART 3 COORDINATION OF BENEFITS CON'T

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 Plan Member ______________________

   Name of other insurance company ______________________ Policy Number ______________________

   b) Is any member of your family (other than yourself) insured as a plan member 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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