Canadian Dental Association

STANDARD DENTAL CLAIM FORM

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.

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

DUPLICATE FORM ☐

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

1. EMPLOYEE COMPLETE PARTS 2 AND 3.
2. HAVE YOUR DENTIST COMPLETE PART 1.
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.
4. SEND THIS CLAIM TO:

THE Great-West Life ASSURANCE COMPANY

A member of the Power Financial Corporation group of companies

The Great-West Life Assurance Co.
Toronto Benefit Payment Office
P.O. Box 4083, Station "A"
Toronto, Ontario
M5W 1M8

PART 2 EMPLOYEE INFORMATION

PLAN NO. 51257 DIVISION NO. _____ EMPLOYEE NO. _____

NAME OF EMPLOYER THE CORPORATION OF THE CITY OF BRAMPTON

YOUR NAME: (PLEASE PRINT) _____ YOUR DATE OF BIRTH: ___/___/___ (DAY / MONTH / YEAR)

PREFERRED LANGUAGE OF COMMUNICATION: FRENCH ☐ ENGLISH ☐

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.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART 3 PATIENT INFORMATION

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 PATIENT IS A CHILD OVER 18:
   A) IS HE/SHE A FULL-TIME STUDENT? YES ☐ NO ☐ IF YES, NAME OF SCHOOL _____
   B) 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 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 ___/___ (DAY / MONTH)
6. IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ NO ☐ IF YES, GIVE DATE, LOCATION, AND EXPLAIN HOW ACCIDENT HAPPENED _____
7. 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 _____