Canadian Dental Association

STANDARD DENTAL CLAIM FORM

THE Great-West Life ASSURANCE COMPANY

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.

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

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.&OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. HAVE YOUR DENTIST COMPLETE PART 1.
2. CLAIMANT COMPLETE 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.
4. SEND THIS CLAIM TO:

Great-West Life Health & Dental Benefits
P.O. Box 4076 Stn A
Toronto ON M5W 3A3
1-800-874-5899
(416) 440-0406

PART 2 CLAIMANT INFORMATION

PLAN NO. **51582** CLAIMANT IDENTIFICATION NO. _____

NAME OF EMPLOYER **TORONTO TRANSIT COMMISSION**

CLAIMANT NAME: (PLEASE PRINT) _____ DATE OF BIRTH: ____/____/____ DAY MONTH YEAR

CLAIMANT ADDRESS _____

PERSONAL INFORMATION WE COLLECT FROM YOU IS KEPT IN STRICT CONFIDENCE AND WILL BE USED TO ASSESS YOUR CLAIM AND TO ADMINISTER THE GROUP BENEFIT PLAN. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE AND THAT ALL OF THE EXPENSES WERE FOR SERVICES AND SUPPLIES RECEIVED BY ME AND/OR MY ELIGIBLE DEPENDENTS. I AUTHORIZE THE RELEASE OF INFORMATION RELATING TO THE EXPENSES ON THIS FORM.

CLAIMANT'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 BETWEEN 21-25, EFFECTIVE JANUARY 1, 2003:
   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? _____
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 CLAIMANT _____
   NAME OF OTHER INSURANCE COMPANY _____ POLICY NUMBER _____
   B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? ☐ YES ☐ NO
   C) IF YES TO QUESTION 5 A) OR B), 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. 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 _____