The Maritime Life Assurance Company

Dental Care Expense

Canadian Dental Association

Maritime Life

PATIENT

LAST NAME | FIRST NAME AND INITIAL

ADDRESS

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 PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF EMPLOYEE

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

PRE-TREATMENT X-RAYS ARE REQUIRED FOR ESTIMATES/CLAIMS INVOLVING MAJOR DENTAL WORK.

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.

OFFICE VERIFICATION

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE OF SERVICE YYYY	MM	DD	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGE
						TOTAL FEE SUBMITTED		

NS Group Claims Department
NB 7 Maritime Place
PE PO Box 1030
NL Halifax NS B3J 2X5
902 453 4300

QC Group Claims Department
Bureau 1200
999 boul de Maisonneuve O
Montréal QC H3A 3L4
514 288 4300

ON Group Claims Department
Maritime Life Tower
2 Queen Street East
PO Box 4607 Stn A
Toronto ON M5W 4Z3
416 687 5007

AB Group Claims Department
MB Suite 3410
SK 450 - 1st Street SW
Calgary AB T2P 5H1
403 750 7320

BC Group Claims Department
YT Suite 1404
NT 1055 Dunsmuir Street
NU PO Box 49284
Vancouver BC V7X 1L3
604 689 1429

DHL Express (Canada) Ltd. **961281**

Plan Sponsor / Employer Policy # Plan Member ID #

Plan Member – Last Name First Name and Initial Date of Birth (yyyy/mm/dd)

Plan Member – Address No. Street City Province Postal Code

Patient – Last Name First Name and Initial Relationship Date of Birth (yyyy/mm/dd)

1. Is the dependent working? ☐ No ☐ Yes or Is the dependent attending school? ☐ No ☐ Yes
2. Are benefits available from another group plan? ☐ No ☐ Yes If yes, please provide the following information _____ Insurance Carrier Name Policy Number
3. If other coverage was available and has recently terminated, please provide termination date _____ (yyyy/mm/dd)

   The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Maritime Life with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.
4. If for denture, bridge, crown or onlay/inlay, is this an initial placement? ☐ No ☐ Yes

   If yes, please provide date(s) teeth were extracted and all other missing teeth in arch _____ (yyyy/mm/dd)
5. If replacement, please provide date of prior placement and reason for replacement _____ (yyyy/mm/dd) Reason _____
6. If treatment is due to an accident, indicate date of accident _____ (yyyy/mm/dd)

7. Do you want any unpaid balance from this claim reimbursed from your **Health Care Spending Account?** (If Eligible) ☐ No ☐ Yes

I authorize The Maritime Life Assurance Company ("Maritime Life") to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Maritime Life will be kept confidential and, where necessary, Maritime Life will be exchanging my personal information. I authorize the following persons to exchange with Maritime Life or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution.

I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Signature of Plan Member (in full) (yyyy/mm/dd)