THE Great-West Life ASSURANCE COMPANY

DENTALCARE

Please print

HEALTHCARE SPENDING ACCOUNT PLAN (SIDE 1)

CANADIAN DENTAL ASSOCIATION

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.

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

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 FOR CLAIM SUBMISSION

IMPORTANT: 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. Employee 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.

PART 2 EMPLOYEE INFORMATION

Employee Name _____ Date of birth ____/____/____ (Day / Month / Year)

Employee address _____

Group or Plan Name **CAPREIT LIMITED PARTNERSHIP** Plan Number **157493** ID Number _____ DIV # _____

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. 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 to exchange personal information when necessary for these purposes. I 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 Name _____ 2. Patient's relationship to employee _____ 3. Patient's Date of Birth: ____/____/____ (Day / Month / Year)
4. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
5. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No If student, how many hours per week at school? _____
   b) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____
6. If patient is other than employee's spouse or a child under 21, is employee entitled to claim a medical expense taxcredit under the Income Tax Act (Canada) in respect of the patient? ☐ Yes ☐ No
7. a) Are you or any other member of your family entitled to dental benefits from any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   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
   If yes, name of family member _____
   c) If yes to questions 7 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/____ (Day / Month)
8. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location, and explain how accident happened

_____

9. 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

_____

TURN OVER FOR SIDE 2

Clear

HCSA CLAIM EXPENSES ARE REIMBURSED IN THEIR ENTIRETY, DEPENDING ON THE AVAILABLE CREDITS. REQUESTS FOR PARTIAL REIMBURSEMENTS CANNOT BE ACCOMMODATED.

SEND THIS CLAIM TO:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
Toll Free: 1-800-263-5742 Or: (519) 435-6903

For the deaf or hard of hearing:
Toll Free: 1-800-990-6654
Or: (204) 946-7281

DENTAL CLAIM FORM COMPLETION — CHECK LIST

1) HAS THE EMPLOYEE SIGNED THE CLAIM FORM – SIDE 1?

2) HAS THE PROVIDER OF SERVICE SIGNED THE CLAIM FORM?

3) HAS ALL THE NECESSARY CLAIM FORM DOCUMENTATION BEEN ATTACHED TO THIS CLAIM FORM? SUCH AS:

   - GREAT-WEST LIFE OR OTHER INSURER'S EXPLANATION OF BENEFITS, (WHERE INSURER HAS ALREADY PROCESSED OR PAID SOME PORTION OF THE CLAIM)

   - PAYMENT MAY BE DELAYED IF THIS FORM IS NOT FULLY COMPLETED.