

DENTALCARE

Please print

HEALTHCARE SPENDING
ACCOUNT PLAN
(SIDE 1)





PART 1 DENTIST												UNIQUE NO. SPEC.					PATIE	ENT'S	S OFF	FICE	ACCOUNT NO	Insurance Association	
Р	LAST										D							FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.					
A	LAUT								GIVE		E												
T I	ADDR	ADDRESS APT.																					
EN																							
T	CITY						PRO	V.	POSTA	CODE	S T	PHO	NE N	0.								SIGNATURE OF SUBSCRIBER	
FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS,												I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCE											
PROCEDURES, OR SPECIAL CONSIDERATION. MY													INDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED IY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE INTIRE TREATMENT.										
													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																							
<u>⊢</u>		E OF SERVICE PROCEDURE TOOTH TOOTH DENT										T'S		ABORA			IOTAL					STRUCTIONS FOR CLAIM SUBMISSION	
DA	Y MO.	YR.	\vdash		ODE	-	+		SURFACES		FEE			CHARGE				CHARGES				ORTANT: All claims under this group benefits are submitted through the plan member.	
			╞				1									╞					Wer	may exchange personal information about	
																					on hi	ns with the plan member and a person acting is or her behalf when necessary to confirm	
	_					_		_							_		-					bility and to mutually manage the claims. Iave your dentist complete Part 1.	
⊢	_		\vdash			_	+	_					+	$\left \right $		╞	+			_		mployee completes Parts 2 and 3. you wish benefits to be paid directly to the	
⊢			┢				┼				-+		+	$\left \right $		┢	+			_	de	lentist, sign the assignment portion of Part 1 bove. Assignment of benefits is irrevocable.	
⊢			╞				╈									╞					G	Great-West Life may discuss details of this	
																\square					cl	laim with the assignee.	
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AND	THE TO	otal fe	EE D	UE	AND	PAYA	ABLE	, E. & (тот	AL	FEE	SU	JBM	ITTE	D							
_			_																		Da	ate of birth / /	
																					D(Day Month Year	
															58	10	1			umb		Div #	
Group or Plan Name T4G LIMITED Plan Number DI 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. 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.																							
	ployee	•											-						_ D	ate		<u> </u>	
PA	RT 3	PATIE	:NI	IN	FOI	KMA		N															
1.	Patien	ťs Na	me						2. Patie	nt's rela	atior	nship t	o en	nploy	ee						3. Pa	atient's Date of Birth: // / Day Month Year	
4.	If the p	patient	IS	a c	hild,	doe	es tr	ie pai	ient reside with	n you?		Yes		No									
5.	If the c	child is	s ov	er	18:	,			a full-time stud													eek at school?	
						emp	loye	e's s		ld unde												ax credit under the Income Tax Act	
							•		your family en		der	ntal be	enefit	ts froi	m any	oth	ier pl	an?		Ye	es 🗌 No		
	lf y	es, na	me	of	fam	ily m	nem	ber ir	isured						-			_ F	Relat	ions	ship to emp	ployee	
																						number	
	lf v	es na	me	of	fam	ilv m	nem	her	her than yours														
	c) If y	es to o	que	stic	ns	7 a)	or b), an	d the patient is	a depe	ende	ent chil	ld, p	lease	provi	de s	spous	se's	Dat	e of	f Birth	/ ay Month	
8.	Is this	treatm	nen	t re	quir	ed a	is th	ie res	ult of an accide	ent?	∃ Ye	es 🗌] No	11	f yes, g	give	e date	e, lo	catio	on, a	and explain	n how accident happened	
9.	If clain	n is fo	r de	entu	ire,	crow	/n o	r brid	ge, is this initia	I place	men	t?	Yes	s	No	lf r	no, gi	ve c	date	of p	orior placer	ment and reason for replacement	

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

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1.800.957.9777

London Benefit Payments 255 Dufferin Avenue London ON N6A 4K1

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

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.