canada life™

STANDARD DENTAL CLAIM FORM

Please print

CANADIAN DENTAL ASSOCIATION

CLHIA ACCAP

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 THE DENTIST.

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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____

DUPLICATE FORM ☐

OFFICE VERIFICATION

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

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 their 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. Canada Life may discuss details of this claim with the assignee.

Send this claim to:

Questions? Call Toll Free: 1-800-957-9777
London Benefits Payment Office
PO Box 5160 Stn. B
London ON N6A 0C6
www.canadalife.com

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

PART 2 EMPLOYEE INFORMATION

Plan Number _____ Division Number _____ Employee Identification Number _____

Plan Name _____

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

Employee address _____

At Canada 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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I authorize Canada 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 Canada 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.

Employee's Signature _____ Date _____

PART 3 COORDINATION OF BENEFITS

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 child is over 18: a) Is the dependent a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Is the dependent 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 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
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/_____/_____ (Day / Month / Year)
6. Is this 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.

_____

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