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Depending on your province of residence, please submit form to:

**Quebec**  
Group Health and Dental Claims  
PO Box 800, Station Maison de la Poste  
Montreal, Quebec H3B 3K5

**Ontario, Atlantic and Western Provinces**  
Group Health and Dental Claims  
PO Box 4643, Station A  
Toronto, Ontario M5W 5E3

**PART 1: DENTIST'S STATEMENT**

Patient (Last and first name)  _____  For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:  _____  Duplicate <input type="checkbox"/> Predetermination <input type="checkbox"/>	Dentist (Last and first name/Address/Phone no.) _____ _____ _____ _____ Signature of subscriber _____ I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$_____ is accurate and has been charged to me for services rendered.  Member's signature _____ Verification (Dentist) _____	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.   _____
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**Treatment and services rendered to the patient**

DATE OF SERVICE			PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEES	LABORATORY CHARGES	TOTAL CHARGES
Y	M	D						

Excluding any possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable. **Total fee submitted**  

**PART 2: MEMBER'S STATEMENT**

Policy no.             Policyholder's name \_\_\_\_\_

Member's last name \_\_\_\_\_ First name \_\_\_\_\_

Certificate no.                         Date of birth                   Sex:  M  F Language:  E  F

**COORDINATION OF BENEFITS**

**IMPORTANT NOTE:**

- If one of your dependents is covered under another plan for dental care expenses, the expenses incurred by this dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.
- The expenses incurred by dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Are you or your dependents covered by another group plan?  No  Yes Specify:

Name of insurance company \_\_\_\_\_ Policy no. \_\_\_\_\_ Coverage:  Individual  Family

Name of spouse or child \_\_\_\_\_ Date of birth                        

**PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.**

1. If expenses are incurred for a dependent, specify:

Last name \_\_\_\_\_ First name \_\_\_\_\_

Relationship to member \_\_\_\_\_ Date of birth 

		Y						M							D
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Children 18 and over:  Handicapped  Full-time student Name of school \_\_\_\_\_

2. If the claim is the result of an accident, specify:  Work  Motor vehicle  Other  
and complete the "Dental Care in Case of an Accident" form (F54-267A)

3. Is any treatment planned for orthodontic purposes?  Yes  No

4. For a denture, crown or bridge, is this an initial placement?  Yes  No IF YES, please submit pre-treatment x-rays.

IF NO, specify date of prior placement 

		Y						M							D
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 and the necessity for replacement: \_\_\_\_\_

5. For a fixed bridge, have you worn or do you currently wear a partial denture?  Yes  No

IF YES, specify date of last placement 

		Y						M							D
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 and the necessity for replacement: \_\_\_\_\_

**MEMBER CONFIRMATION/AUTHORIZATION**

**I HEREBY CONFIRM** that the information contained in this claim form is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to this claim.

On behalf of myself and my dependents:

(1) **I consent to the RELEASE** of the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and

(2) **I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to the Company, its employees, agents and service providers any information regarding the treatment charges incurred which they may need in the assessment of the claim.

(3) **I UNDERSTAND AND AUTHORIZE** that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, the Company will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

**I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

**I AUTHORIZE** the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

**I AGREE** that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** \_\_\_\_\_ Date 

		Y						M							D
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Address \_\_\_\_\_ Postal code 

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Home phone 

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 Work phone 

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 Ext. 

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