THE Great-West Life ASSURANCE COMPANY

CLAIM FORM
DENTAL CARE PLAN

Please print

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. 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)

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 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.
4. Send this claim to:

QUEBEC RESIDENTS, OTHER THAN NATIONAL CAPITAL REGION RESIDENTS:
Montreal Benefit Payments
Place Bonaventure, Suite 5800
800 de la Gauchetière St. W
Montreal QC H5A 1B9
1-800-663-2817, (514) 878-1288
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654
Phone: (204) 946-7281

FOR ALL OTHER RESIDENTS:
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 4E5
1-800-957-9777
(204) 942-3589
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654
Phone: (204) 946-7281

PLEASE KEEP A COPY OF THIS FORM, RECEIPTS AND ANY OTHER REVELANT DOCUMENTATION FOR YOUR RECORDS

PART 2 EMPLOYEE (please print)

1. Employee's Last Name First Name

Date of Birth Day Month Year | Plan Number **5 1 0 5 7** | Employee ID No.

Employee's Address Postal Code

2. Relationship of patient to employee | Patient's Date of Birth Day Month Year | Is the patient a dependent child with a disability age 22 or over? ☐ Yes ☐ No

3. If patient is a dependent child between 22 & 25 years old, is he/she a full-time student? ☐ Yes ☐ No

4. Are you or any member of your family entitled to dental benefits from any other group insurance? ☐ Yes ☐ No

If yes, give name of other insurance company/dental plan | Name of family member insured | Policy No. | I.D. No.

5. If yes to question 4 above, and patient is a dependent child, give spouse's birthday (day/month): _____/_____/

6. Is treatment required as the result of an accident? ☐ Yes ☐ No

If yes, give date, location, and explain how accident happened

If yes, are you a member of the Extended Health Care Plan? ☐ Yes ☐ No

7. If claim is for denture, crown or bridge, is this an initial placement? ☐ Yes ☐ No

If no, give date of prior placement and reason for replacement.

8. Is this claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

Language Preference ☐ English ☐ French

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 _____

CLEAR

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