DENTAL BENEFITS CLAIM FORM

BENEFIT PLAN ADMINISTERED BY:
BENEFIT PLAN ADMINISTRATORS LIMITED

Canadian Dental Association

Canadian Life and Health Insurance Association Inc

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

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 & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.

ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, FLUORIDE TREATMENTS, X-RAYS, BASIC RESTORATIONS AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PREDETERMINATION OF BENEFITS.

X-RAYS MAY BE REQUESTED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIM FORMS, PREDETERMINATIONS AND X-RAYS TO:

BENEFIT PLAN ADMINISTRATORS LIMITED
P.O. BOX 6020, STATION B
ETOBICOKE, ONTARIO
M9W 7A3

PART 2 MEMBER'S STATEMENT *(Complete this part before taking the form to your dentist's office)*

1. MEMBER'S NAME: _____ (PLEASE PRINT) S.I.N. OR IDENTIFICATION NO. ☐☐☐-☐☐☐-☐☐☐ LOCAL UNION _____

ADDRESS: _____ TELEPHONE NUMBER: _____

DATE OF BIRTH _____

2. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH _____
IF CHILD AGE 21 AND OVER, INDICATE ☐ FULLTIME STUDENT ☐ HANDICAPPED
DATE ENROLLED _____ DATE COMPLETED _____

3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOV'T. AGENCY OR DENTAL PLAN? ☐ NO ☐ YES
POLICY NUMBER _____
NAME OF INSURING AGENCY _____
IF CLAIMS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

4. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
GIVE DATE AND DETAILS

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES
IF INITIAL PLACEMENT ADVISE DATE TEETH WERE EXTRACTED _____
AND ALL OTHER MISSING TEETH IN ARCH _____
IF REPLACEMENT GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT

6. IS YOUR DEPENDENT EMPLOYED? ☐ NO ☐ YES
IS YOUR DEPENDENT ATTENDING SCHOOL? ☐ NO ☐ YES
IF SO, GIVE NAME OF EMPLOYER OR SCHOOL

AUTHORIZATION: On behalf of myself and eligible dependents, I authorize my employer and my group benefit provider, to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

SHOULD THE ABOVE MEMBER IDENTIFICATION NUMBER REPRESENT MY SOCIAL INSURANCE NUMBER, I HEREBY AUTHORIZE MY BENEFIT PLAN ADMINISTRATOR TO USE MY SOCIAL INSURANCE NUMBER FOR PURPOSES OF ADMINISTRATION OF MY GROUP BENEFIT PLAN. I UNDERSTAND THAT MY SOCIAL INSURANCE NUMBER WILL BE KEPT IN STRICTEST CONFIDENCE AND WILL ONLY BE USED FOR THE PURPOSE HEREIN.

DATE _____ / _____ / _____
DAY MONTH YEAR

SIGNATURE

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS