STANDARD DENTAL CLAIM FORM

The Great-West Life
Assurance Company

PART 1 DENTIST

UNIQUE NO. | SPEC | PATIENTS 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 INFORAMTION, 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/DENTISTS SIGNATURE

DATE OF SERVICE DAY	MO	YR	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVCIES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. HAVE YOUR DENTIST COMPLETE PART 1
2. EMPLOYEE COMPLETE PAGES 2 AND 3.
3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
4. SEND THIS CLAIM TO:

Great-West Life Health & Dental Benefits
P.O. Box 3050
Winnipeg, Manitoba
R3C 4E5
1-800-957-9777
(204)942-3589

PART 2 EMPLOYEE INFORAMTION

PLAN NO. 51189 DIVISION NO. _____ EMPLOYEE IDENTIFCATION NO _____

NAME OF EMPLOYER TRUSTEES OF THE WELFARE FUND, I.B.E.W. LOCAL 353

EMPOLYEE NAME: (PLEASE PRINT) _____ DATE OF BIRTH ____/____/____ (DAY / MONTH / YEAR)

EMPLOYEE ADDRESS _____

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my Social Insurance Number as an identification number where it is required in the administration of my group benefit plan. I authorize Great-West, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Great-West to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART 3 PATIENT INFORMATION

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 PATIENT IS A CHILD OVER 18: A) IS HE/SHE A FULL-TIME STUDENT ☐ YES ☐ NO
   B) IF STUDENT, HOW MANY HOURS PER WEEK AT SCHOOL? _____
   C) IS HE/SHE 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 QUESTION 5 A) OR B), AND THE PATIENT IS A DEPENDENT CHILD, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ____/____ (DAY / YEAR)
6. IS 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. _____