THE Great-West Life ASSURANCE COMPANY

STANDARD DENTAL CLAIM FORM

Please print

Canadian Dental Association

Canadian Life and Health Insurance Association

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

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:

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

PART 2 EMPLOYEE INFORMATION

Plan No. **51189** Division No. _____ Employee Identification No. _____

Plan Name. **I.B.E.W. L.U. 353 WELFARE PLAN**

Employee name _____ Date of birth ____/____/____ Day Month Year

Employee address _____

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 authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. 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 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 questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/____ Day Month
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

_____

M445D(51189) BIL-10/04

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