ses benefits™ smart employee solutions

Canadian Life and Health Insurance Association Inc.

CANADIAN DENTAL ASSOCIATION

## 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 TO HIM/HER

SIGNATURE OF SUBSCRIBER

**PATIENT**

FIRST NAME _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

**DENTIST**

PHONE NO. _____

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

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 |
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THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

**TOTAL FEE SUBMITTED**

FOR CARRIER USE

| ALLOWED AMOUNT | INC | % | PATIENT'S SHARE |
|---|---|---|---|
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| CHEQUE NO. | DATE |
|---|---|
| | |

| DEDUCTIBLE | PATIENT PAYS | PLAN PAYS |
|---|---|---|
| | | |

CLAIM NO. _____

## INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

## PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO._____DIVISION/SECTION NO._____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

## PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED
DAY MONTH YEAR

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ☐ NO ☐ YES

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. ☐ NO ☐ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

## PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

| | DAY | MONTH | YEAR |
|---|---|---|---|
| 1. DATE COVERAGE COMMENCED | | | |
| 2. DATE DEPENDENT COVERED | | | |
| 3. DATE TERMINATED | | | |

4. CONTRACT HOLDER

| DATE | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| DAY | | MONTH | | YEAR | |

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

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