

STANDARD DENTAL CLAIM FORM Please print





PΑ	ART 1 DENTIST UNIQU													UN	IIQUI	E N	O.		SPE	<u>5.</u>	F	ATIEN	IT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS
	LAST		7900			!						GIV	EN NAME	D								•••••		PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE
A T	ADDF													E		PAYMENT DIRECTLY TO HIM/HER.								
ļ!	AUUN	iess											APT.	T										
E N T	CITY						-	PF	NOF.			POST	AL CODE											
FOI										ONAL INFORMA	ATIO	N, DIA	GNOSIS,		UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY									
PR	DOED	URES	3, C	RS	PEC	CIAL	CO	NSID	ERATIO	NC.					PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE REATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS BEEN									
															CHARGED TO ME FOR SERVICES RENDERED. AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING									
														co	MPA	NY	PLAN	ADM	iNIS	TRAT	TOR	. I ALS		INICATION OF INFORMATION RELATED
															IGNATURE OF PATIENT (PARENT/GUARDIAN)									
DUI	DUPLICATE FORM []														PFICE VERIFICATION									
	OF S			P		EDI		- IN	VTLTOOT CODE			DENT		LA	LABORATORY CHARGES TOTAL CHARGES							GES		STRUCTIONS
יאט	IVIC.	D. YR. CODE						+	T	SURFACES	DES FEE			Change								T	All claims under this group benefits plan are submitted through the plan member. We may exchange personal information	
	_	_	+	+	\dashv	\dashv	\dashv	+						╁	\vdash				+	+	+		about claims with the pl	an member and a person acting on necessary to confirm eligibility and to
	+	+	†	\dashv	\dashv	十	+	+											+	+	+	 	mutually manage the clai 1. Have your dentist com	ims.
			\forall	_	7	十	\dashv	\top					<u> </u>	1				_	+	+	\dagger		Employee completes I	Parts 2 and 3.
	<u> </u>	1	†	\top		寸	T	十				_		İ					_	_			assignment portion of	be paid directly to the dentist, sign the Part 1 above. Assignment of benefits
			T	_	7	7					-			T					Ť				is irrevocable. Great-\ claim with the assigne	West Life may discuss details of this e.
		T				\top									П					<u> </u>	†		4. Send this claim to:	
																							Questions? Call T	oll Free: 1.800.957.9777
																							Winnipeg Benefit F	
			_	_																			PO Box 3050 Stati Winnipeg MB R30	
<u> </u>	ļ		1																\perp					or hard of hearing:
	1			Ц										<u> </u>					L		<u></u>	<u></u>		300.990.6654
THIS	SIS AN	V ACC TOTA	LF	EE I	ST	ANI	MEI DP/	NT OF AYAB	ESERV LE, E. 8	ICES PERFORM LO.E.	1ED.	TOT	AL FEE	SU	ВМ	ΙΙΤ	TED							
P/	RT:	2 E	MF	LC	ΥE		ΝF	ORI	OITAN	N		- Contraction of the Contraction		-										- to the same of t
PI	an N	lumb	er					5	8536		-	Divisi	on Nun	nbe	r			1				Em	plovee Identification Nu	ımber
																								BERTA
																								Date of birth//
																								Day Month Year
At	Gre	at-W	les	t L	ife	we	re	coa	nize a	ind respect t	he i	mpor	tance o	of ne	riva	CV	Pers	onal	linf	orm	atin	n tha	at we collect will be use	ed for the purposes of assessing
yo ar	ur el d pra	aim actic	an es	da (in	dm clu	inis din	ter a w	ing t vith r	the gro resper	oup benefits of to service	plar prov	ı. For viders	a copy s), write	of o	our Gre	Pri at-	ivacy West	Guid Life	deli 's (nes, Chie	or f Co	if you ompli	I have questions about ance Officer or refer to	our personal information policies www.greatwestlife.com
Ιź	autho	orize	G	rea	ıt-V	Ves	t Li	ife, i	any h	ealthcare pr	ovid	ler, m	iy plan	adr	nini	str	ator.	othe	er ir	sura	anc	e or	reinsurance companie	s. administrators of government
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, located within or outside Canada, to exchange personal information when personal information may be subject to displaying to those authorized under																								
personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.																								
Er	Employee's Signature																		~~~~		Dat	e		
P/	\RT	3 C	00	ΣŘÍ	ЭĬЙ	ΑT	101	N OF	BEN	EFITS					••••••	···								
1.	Pat	tient	's r	ela	tio	nsh	ip 1	to yo	ou														2. Patient's date of	birth / / Day Month Year
3.	lf th	ъ р	atie	∍nt	is :	a cl	nild	l, do	es the	e patient resi	ide ۱	with y	∕ou? 🗆) Ye	es		No							Day Month Year
4.	lf th	ne cl	hilo	l is	οv	er	18:	a)	ls he/	she a full-tin	ne s	tuder	nt? 🗀	ÌΥe	es		No							
								b)	if stuc	dent, how ma	any									***************************************			*******	
								c)	Is he/	she employe	ed?] Ye	es		No	If ye	s, l	how	ma	iny h	ours worked per week?	}
5.	a)	Are	yo	u c	or a	ny	oth	ier n	nembe	er of your fai	mily	entit	led to b	ene	efits	นก	ider a	iny o	othe	er pla	an?)	☐ Yes ☐ No	
		Nar	ne	of	oth	er i	nsı	⊔ran	ce co	mpany												Polic	y Number	
			-					-			-							-				•	? ☐ Yes ☐ No	
																		ise p	orov	/ide	spc	ouse'	s Date of Birth	/ / Month Year
6.							-			result of an														
_	-		•							•			• •									•		
					_					·=										c				
7. Is a claim being made for Worker's Compensation Benefits?												mal ţ	ласете	ent?	_) Y (es L	_1 1 V (ו כ	no,	giv	e da	te of prior placement at	nu reason for replacement.