ACCIDENTAL DENTAL FORM

Group Policy Number: **Certificate Number:**

Insured Employee: **Patient:**

Date of Accident: (mm/dd/yyyy) _____ **Was the accident in Canada?** Yes ☐ No ☐

If No, Departure Date: (mm/dd/yyyy) _____ Return Date: (mm/dd/yyyy) _____

Describe the accident:

_____

_____

_____

_____

Please attach a copy of the police report and/or hospital report. Attached ☐ Not applicable ☐

Authorization

I _____ **authorize:**

- any person or organization, including the relevant physicians, hospitals and other service providers or facilities, to release full information and records with respect to this claim to Empire Life;
- Empire Life, its agents, representatives, consultants, other insurance companies and reinsurers to collect, review, maintain and exchange this information with each other (as deemed necessary) for the purpose of reviewing, assessing and managing this claim.

Signature of Insured: _____ **Date: (mm/dd/yyyy)** _____

Note to your Dentist

- identify the teeth damaged and provide a complete clinical description,
- include the codes and related fees for the dental work required as a result of this accident,
- include any relevant photos or x-rays, and
- accident claims cannot be submitted via EDI.

Please send any dental office claim forms and accident reports to our office for review and assessment.

If you have any questions contact our Customer Service Unit (1-800-267-0215) for assistance.