

**STANDARD DENTAL CLAIM FORM**



Approved by the Canadian Dental Association

<b>PART 1 DENTIST</b>	UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.
P LAST NAME A GIVEN NAME T ADDRESS APT. I CITY PROV. POSTAL CODE N T PHONE NO	D E N T I S T			SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION  DUPLICATE FORM <input type="checkbox"/>	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/DENTIST'S SIGNATURE	

DATE OF SERVICE			PROCEDURE CODE	INT'L. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						

We strongly recommend that if charges will be \$300.00 or more your claim be submitted for predetermination of benefits before the work is started. The submission of x-rays will be required for crowns or bridgework. These will be returned promptly to your dentist.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE.	<b>TOTAL FEE SUBMITTED</b>
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**PART 2 INSURED/SUBSCRIBER** COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

Group Policy No. \_\_\_\_\_ Division No. \_\_\_\_\_ Employer \_\_\_\_\_

Cert. No. \_\_\_\_\_ Name of Subscriber \_\_\_\_\_

Patient: relationship to Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_

If child, is he/she employed? No  Yes  - Where? \_\_\_\_\_ # Hrs. Worked \_\_\_\_\_

Is he/she wholly dependent on you for support? No  Yes

If child age 21 or over, indicate Student: Full time  Part time  if Handicapped

If student, indicate school \_\_\_\_\_

Are any dental benefits or services provided under any other Group Insurance or Dental Plan? No  Yes  Policy No. \_\_\_\_\_

Name of Insuring Agency \_\_\_\_\_

If yes, provide spouse's Date of Birth \_\_\_\_\_ and Subscriber's Date of Birth \_\_\_\_\_

If denture, crown or bridge, is this initial placement? No  Yes  Give date of prior placement and reason for replacement \_\_\_\_\_

Is any treatment required as the result of an accident? No  Yes  Give date and details \_\_\_\_\_

Is any treatment for orthodontic purposes? No  Yes  Is claim being made for Workers' Compensation Benefits? No  Yes

I certify that the statements above are complete and true and that all attached receipts represent no duplication of charges previously submitted.

I authorize:

- The release of full information and records with respect to this claim to The Empire Life Insurance Company (Empire Life) and I authorize Empire Life, its agents, representatives or consultants to collect and review this information (as deemed necessary) for the purpose of reviewing, assessing and managing this claim;
- Empire Life to release to the policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management;
- Empire Life to reimburse the insured plan member directly with respect to this claim.

I agree a photocopy of this authorization shall be as valid as the original.

I understand all claims made under this Group Plan are submitted through the insured plan member. Empire Life may exchange information about these claims with the insured plan member or any person acting on his or her behalf (as deemed necessary) for the purpose of confirming eligibility and assessing and managing the claim.

Date: \_\_\_\_\_ Signature of Claimant: \_\_\_\_\_

In order to obtain prompt payment of your claim, did you...

Complete and sign your claim form?  
Include your correct current address and postal code?  
Include a copy of the Explanation of Benefits from your other insurance company if  
co-ordinating benefits?

If assigning payment directly to your dentist, please ensure that the assignment portion of  
the Dental Claim Form is completed.

Empire Life reserves the right to ask for additional information in order to assess this or  
any future claims.

Claims submitted more than 365 days from the date of service or more than 90 days after  
termination of coverage will be declined as too late to allow.

When Completed, Please Mail Your Claim Form To:

The Empire Life Insurance Company  
Group Health Claims  
259 King Street East  
Kingston ON  
K7L 3A8

Your claim payment will be sent to the address on the claim form.  
Missing or incorrect information results in unavoidable delays in claims payment.

Take advantage of automatic payments deposited to your bank account via  
EFT (electronic funds transfer).  
To begin receiving your dental claim payments by this method simply attach a void cheque  
to this claim form.

Insurance Fraud  
Insurance Fraud is an intentional act or omission with a view to illegally obtaining an  
insurance benefit.  
Fraudulent claims increase the cost of your group insurance.

Group Customer Service Unit 1-800-267-0215