## **EMPIRE LIFE DENTAL CLAIM FORM**

Throughout this form, "Empire Life" means the Empire Life Insurance Company.

Part 1 - To be completed by the Dentist	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.	
	D			autionze payment directly to himmer.	
A	N				
Address APT	Ţ				
E City	S			<u>X</u>	
T Province Postal code	T Phone No.			Signature of subscriber	
For dentist's use only - for additional information, diagnosis, proce	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 re-sponsible 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 communi-cation of information related to the coverage of services described in this form to the named dentist.				
l aut com					
			X		
			-	Patient (Parent/Guardian)	
Duplicate Form Office verification/Dentist signature					
Duplicate Form Office verification/Dentist signature					
DATE OF SERVICE PROCEDURE CODE INTL TOOTH DAY MO. YR. CODE SURFACES	DENTIST'S FEE	LABORATOR CHARGE		strongly recommend that if charges	
DAY MO. YR. CODE SURFACES				be \$300.00 or more, your claim be	
				nitted for predetermination of benefits ore the work is started. The submission -rays will be required for crowns or gework. These will be returned promptly	
				bur dentist.	
This is an accurate statement of services performed and the total fee due and payable, E & OE.	TOTAL FEE SUBMI				
Part 2 - Insured/Subscriber - Complete this pa			vour Deptist's office		
Group policy No. Division No.					
Name of subscriber			_ Date of birth		
Part 3 - Patient Information					
1. Patient relationship to Subscriber     Date of birth					
If a child, is he/she employed?       yes       no - If yes, specify where       Number of hours worked					
Is he/she wholly dependent on you for support?			indicate: () Handicapped ()		
If a student specify: $\bigcirc$ Full time $\bigcirc$ Part time - part	me of school				
2. Are any dental benefits or services provided under any other Group Insurance or Dental Plan? O yes O no - if yes:					
	any other droup				
Name of Insurance Agency		Policy num	iber Spous	se's date of birth	
Name of Insurance Agency 3. If denture, crown or bridge, is this initial placement?	? () yes () no	- if no:	ber Spous	e's date of birth	
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## 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.

## Please mail your completed claim form to:

Group Solutions Empire Life 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

