THE Great-West Life ASSURANCE COMPANY

STANDARD DENTAL CLAIM FORM

Please print

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association

PART 1 DENTIST

UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.

PATIENT

LAST NAME _____ GIVEN NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

DENTIST

PHONE NO. _____

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF POLICYOWNER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

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

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this plan are submitted by the policyowner. We may exchange personal information about claims with the policyowner and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Policyowner completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

The Great-West Life Assurance Company
Individual Health Unit
PO Box 6000
Winnipeg MB R3C 3A5

For inquiries call: 1-866-430-2863

PART 2 POLICYOWNER INFORMATION

Policy Number __/__/__/__/__/__/__/ - __/__/__/__/__/__/__/__/__/__/

Policyowner Name (please print) _____

Policyowner Address _____

Phone Number: Home _____ Work _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator (if applicable), 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 necessary for these purposes. I certify the information given is true, correct and complete to the best of my knowledge.

Policyowner's Signature _____ Date _____

This claim will be returned to you if it is incomplete or contains errors. Please keep a copy for your records.

PART 3 PATIENT INFORMATION

1. Patient's relationship to you: _____ 2. Patient's date of birth: _____ /_____ /_____ (Day / Month / Year)
3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
4. If the patient is a child over 18 but under 25 years of age:
   a) Is he/she a full-time student? ☐ Yes ☐ No If Yes, name of school? _____
   b) Is he/she employed? ☐ Yes ☐ No If Yes, how many hours worked per week? _____
5. a) Are you or any other member of your family entitled to benefits from any other source? ☐ Yes ☐ No ☐ Group ☐ Individual
   If Yes, name of family member insured _____
   If Yes, name of other insurance company _____ Policy number _____
   b) If Yes to question 5 a), and the patient is a dependent child, please provide spouse's date of birth _____ /_____ /_____ (Day / Month / Year)
6. Is treatment required as a result of an accident? ☐ Yes ☐ No If Yes, give date, location, and explain how accident happened.

_____

7. If claim is for denture, crown or bridge, is this an initial placement? ☐ Yes ☐ No If No, give date of prior placement and reason for replacement.

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