THE Great-West Life ASSURANCE COMPANY

CLAIM FOR DENTAL BENEFITS
POLICY NUMBER 158879 - AMAPCEO
GOVERNMENT OF ONTARIO EMPLOYEES PLAN

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association

PART 1 DENTIST

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

PATIENT
P 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.

PLEASE PAY SUBSCRIBER

SIGNATURE OF SUBSCRIBER

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____

OFFICE VERIFICATION / DENTIST'S SIGNATURE

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

Ontario

INSTRUCTIONS FOR COMPLETION AND MAILING OF CLAIM FORM

1. A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH PATIENT.
2. HAVE YOUR DENTIST COMPLETE PART 1.
3. FULLY COMPLETE ALL QUESTIONS IN PART 2, EMPLOYEE STATEMENT.
4. SEND FORM TO:
   Toronto Benefit Payments
   P.O. Box 4076 Stn A
   Toronto ON M5W 3A3
   Toll Free: 1.800.874.5899

   For the deaf or hard of hearing:
   Toll Free: 1.800.990.6654
5. SEE BOOKLET FOR DETAILS OF GROUP DENTAL PLAN.

PART 2 - STATEMENT MUST BE COMPLETED IN FULL BY INSURED EMPLOYEE

☐ MR. ☐ MRS. ☐ MS. ☐ MISS

1. INSURED EMPLOYEE'S NAME _____
   INITIALS _____
   EMPLOYEE IDENTIFICATION NO. OF INSURED EMPLOYEE _____
2. ADDRESS _____ APT. NO. _____
   _____
   _____ POSTAL CODE _____
3. PATIENT IS (A) ☐ SELF ☐ SPOUSE _____ (First Name)
   (B) ☐ SON ☐ DAUGHTER _____ (Child's First Name)
   CHILD'S DATE OF BIRTH _____ (Day Month Year)
   CHILD'S STATUS ☐ MARRIED ☐ SINGLE
   FULL-TIME STUDENT? ☐ YES ☐ NO
   FINANCIALLY DEPENDENT? ☐ YES ☐ NO
4. (A) IS PATIENT INSURED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ☐ YES ☐ NO
   POLICY NUMBER _____
   NAME & ADDRESS OF INSURING AGENCY _____
   _____

4. (B) IF YES TO QUESTION #4(A), AND PATIENT IS A DEPENDENT CHILD, PLEASE PROVIDE:
   EMPLOYEE'S BIRTHDATE _____ (Day Month)
   AND SPOUSE'S BIRTHDATE _____ (Day Month)
5. IF SPOUSE INSURED UNDER SAME PLAN, OR PLAN 330021 PLEASE PROVIDE EMPLOYEE IDENTIFICATION NO. _____
6. IS ANY DENTAL TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO
   GIVE DATE _____
   GIVE DETAILS _____
   _____
   _____
7. IS A DENTAL CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO
8. WERE ANY OF THE DENTAL PROCEDURES CARRIED OUT IN HOSPITAL? ☐ YES ☐ NO
9. MINISTRY OR ORGANIZATION OF ACTIVE INSURED EMPLOYEE
   _____
   _____

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 and administering the group benefits plan.

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 necessary for these purposes.I certify that the information given is true, correct and complete to the best of my knowledge.

DATE _____ **EMPLOYEE'S SIGNATURE** _____

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