CLAIM FOR DENTAL BENEFITS
ONTARIO PUBLIC SERVICE EMPLOYEES UNION (OPSEU)

Please print

PART 1 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 THE DENTIST.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

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 group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on their behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee 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. Canada Life may discuss details of this claim with the assignee.
4. Send this claim to:

Questions? Call Toll Free: 1.800.874.5899

London Benefit Payments
PO Box 5111 Station B
London ON N6A 0C5
www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us: TTY to Voice: 711
Voice to TTY: 1-800-855-0511

PART 2 EMPLOYEE INFORMATION

Plan Number **330021** Employee Identification Number _____

Plan Name **ONTARIO PUBLIC SERVICE EMPLOYEES UNION (OPSEU)**

Employee Name _____ Date of birth ____/ _____/_____
Day Month Year

Employee address _____

I certify that the information that I have provided on this claim form is true, accurate and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible for benefits coverage under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of false or misrepresented claims seriously. I understand and acknowledge that:

- Canada Life may reassess my claim(s) being submitted at any time including but not limited to, any circumstance where the information on a receipt differs from my claim(s) being made;
- my submission of any claim(s) investigated and determined by Canada Life to be false or misrepresented will be reported, together with any relevant information including evidence resulting from the investigation, to my plan sponsor and/or my employer, including its agents, and the appropriate law enforcement agency;
- Canada Life will pursue the recovery of any money that has been obtained improperly through false or incorrect claim submission.

What could happen if I submit a false or misrepresented claim?

- You could lose your benefits. In addition to having to pay the money back, you could lose your benefits completely
- You could go to jail. Being convicted of fraud results in a criminal record – making it difficult to get a job or travel
- You could lose your job. After all, stealing from your employer is a serious offence, and many employers have a zero-tolerance policy for benefits fraud. Being fired for benefits fraud could also impact your chances of being employed in the future.

At Canada 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 Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for purposes of the administration of my benefits. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Employee's Signature _____ Date _____

canada life™

PART 3 COORDINATION OF BENEFITS

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 child is over 18: a) Is the dependent a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Is the dependent 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 under any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy Number _____
   b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____ /_____/_____ Day Month Year
6. Is this treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, give date, location, and explain how accident happened _____
7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement.
   _____

Clear