Equitable Life of Canada®

Head Office
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Ontario N2J 4C7
TF 1.800.265.4556 **F** 519.883.7406

DENTAL CLAIM FORM

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 HIM/HER.

PATIENT

LAST NAME | GIVEN NAMES
ADDRESS | APT.
CITY | PROVINCE
POSTAL CODE

DENTIST

NAME
ADDRESS
POSTAL CODE
TELEPHONE NO.

SIGNATURE OF SUBSCRIBER (INSURED)

FOR DENTIST 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 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			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL
Day	Mo.	Yr.						

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

TOTAL FEE SUBMITTED $

Falsifying or tampering with claim documents / receipts could have legal consequences.

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE YOUR DENTIST COMPLETE PART 1, 2 AND 3.
2. AFTER PART 1 IS COMPLETE, SIGN PART 1 ACKNOWLEDGING DENTIST'S FEE.
3. ENSURE COMPLETION OF PART 2 AND 3 IN FULL. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR CLAIM.

PART 2 - EMPLOYER/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO: ______ DIVISION NO: ______

   EMPLOYER: ______

2. INSURED'S NAME (PLEASE PRINT): ______

   DATE OF BIRTH: (Day______Month______Year ______) INSURED'S CERTIFICATE/I.D. NO: ______

Please complete reverse side →

520(2007/04/26)

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DENTAL CLAIM FORM

IF YOU HAVE A HEALTH CARE SPENDING ACCOUNT (HCSA) PLEASE COMPLETE THE FOLLOWING.

TO ENSURE YOU MAXIMIZE YOUR BENEFIT COVERAGE, REVIEW ANY COVERAGE YOU HAVE THROUGH ANY PROVINCIAL HEALTH INSURANCE OR PRIVATE PLAN AND CLAIM ACCORDINGLY. A PRIVATE PLAN MAY INCLUDE BENEFIT COVERAGE YOU AND/OR YOUR DEPENDENTS HAVE THROUGH ANOTHER INSURANCE CARRIER. YOU MAY FIND IT USEFUL TO REVIEW THE COORDINATION OF BENEFITS PROVISIONS IN YOUR PLAN MEMBER BOOKLET/BROCHURE.

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

- ❑ I WANT MY ELIGIBLE EXPENSES PAID FROM MY EQUITABLE LIFE HEALTH OR DENTAL PLAN ONLY
- ❑ I WANT MY ELIGIBLE EXPENSES PAID FROM MY EQUITABLE LIFE HEALTH OR DENTAL PLAN FIRST AND MY UNPAID PORTIONS OF MY ELIGIBLE EXPENSES PAID FROM MY HCSA.
- ❑ I WANT ALL MY ELIGIBLE EXPENSES PAID DIRECTLY FROM MY HCSA

PLEASE NOTE:
IF YOU DO NOT SELECT ANY OF THE ABOVE OPTIONS, NO PORTION OF THIS CLAIM WILL BE PAID FROM YOUR HEALTH CARE SPENDING ACCOUNT (HCSA)

PART3 PATIENT INFORMATION

1. **PATIENT**: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER - ____________ DATE OF BIRTH: (Day______Month______Year__________)

   IF CHILD, INDICATE: ❑ STUDENT ❑ HANDICAPPED

   IS HE/SHE ATTENDING SCHOOL FULL TIME? ❑ NO ❑ YES → IF YES, INDICATE SCHOOL: ____________

   WHEN WILL HIS/HER SCHOOLING BE COMPLETED? (Day______Month______Year __________)

   IS HE/SHE EMPLOYED FULL TIME? ❑ NO ❑ YES IS HE/SHE EMPLOYED PART TIME? ❑ NO ❑ YES → HOW MANY PART TIME HOURS PER WEEK? ____________

2. ARE DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN OR CONTRACT? ❑ NO ❑ YES → IF YES, INDICATE THE FOLLOWING:

   NAME OF OTHER INSURING AGENCY OR PLAN:____________ POLICY NO: ____________

   IF THIS PLAN IS ALSO WITH EQUITABLE LIFE®, PLEASE INDICATE MEMBER'S I.D.: ____________

   DO YOU WANT US TO CO-ORDINATE BENEFITS (PROCESS BOTH CLAIMS)? ❑ NO ❑ YES → IF YES,

   SPOUSE'S SIGNATURE: ____________ DATE: (Day______Month______Year __________)

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ❑ NO ❑ YES → IF YES, GIVE DATE AND DETAILS SEPARATELY.

   A) ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ❑ NO ❑ YES
   (ie. School Insurance, Workers' Compensation, etc.)

4. IS THIS CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? ❑ NO ❑ YES

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ❑ NO ❑ YES → IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.

6. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ❑ NO ❑ YES

7. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER/PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
   THE CLAIM INFORMATION WILLINGLY PROVIDED BY ME TO EQUITABLE LIFE HELD IN THEIR FILE, WILL BE USED BY EQUITABLE LIFE FOR THE PURPOSES OF CLAIMS PROCESSING AND ADJUDICATION. I UNDERSTAND AND AUTHORIZE THAT FOR THE ABOVE PURPOSES THE PERSONAL INFORMATION ON FILE IS ACCESSIBLE TO, AND MAY BE EXCHANGED WITH, AUTHORIZED EMPLOYEES OF, AND RELEVANT THIRD PARTIES RETAINED BY EQUITABLE LIFE, ITS SALES DISTRIBUTION NETWORK, PARTICIPATING REINSURER(S), OTHER INSURANCE COMPANIES, INVESTIGATIVE ORGANIZATIONS, HEALTH CARE PROVIDERS, INCLUDING, BUT NOT LIMITED TO, PHARMACIES, PHYSICIANS, DENTISTS, AND ANY OTHER PERSON OR PARTY WHOM I AUTHORIZE.
   IF APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION ALSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES. I UNDERSTAND THAT CLAIMS MADE UNDER THE GROUP INSURANCE POLICY ARE SUBMITTED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE EQUITABLE LIFE TO EXCHANGE INFORMATION ABOUT THESE CLAIMS WITH ME OR ANY PERSON ACTING ON MY BEHALF, INCLUDING A SPOUSE OR DEPENDENT, AS DEEMED NECESSARY FOR THE PURPOSE OF CONFIRMING ELIGIBILITY AND ASSESSING AND MANAGING THE CLAIM.

____________________________ DATE: Day______Month______Year __________)
SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

Falsifying or tampering with claim documents / receipts could have legal consequences.

Please complete reverse side →