THE Great-West Life ASSURANCE COMPANY

L.I.U.N.A LOCAL 183

CLAIM FOR DENTAL EXPENSE BENEFITS

CANADIAN DENTAL ASSOCIATION

CLHIA ACCAP

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 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. 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

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.
ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PERDETERMINATION OF BENEFITS.
X-RAY MAY BE REQUESTED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIM FORMS, PREDETERMINATIONS AND X-RAYS TO:

LOCAL 183 TRUST ADMINISTRATION
1263 WILSON AVE, SUITE 205
NORTH YORK, ONTARIO M3M 3G2
TELEPHONE: 416.240.7487

PART 2 - PLAN MEMBER'S STATEMENT *(Complete this part before taking the form to your dentist's office)*

1. PATIENT: RELATIONSHIP TO PLAN MEMBER _____ DATE OF BIRTH _____
   IF CHILD AGE 21 OR OVER INDICATE ☐ STUDENT ☐ HANDICAPPED
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOV'T. AGENCY OR DENTAL PLAN? ☐ NO ☐ YES
   POLICY NUMBER _____
   NAME OF INSURING AGENCY _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
   GIVE DATE AND DETAILS _____
4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES
5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES
   GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
   _____
6. IS YOUR DEPENDANT EMPLOYED? ☐ NO ☐ YES
   IF SO, GIVE NAME OF EMPLOYER _____
7. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ NO ☐ YES
8. PLAN MEMBER'S NAME: _____
   (PLEASE PRINT)

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

IDENTIFICATION NUMBER: ☐☐☐ ☐☐☐ ☐☐☐

DATE OF BIRTH _____

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. 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 Chief Compliance Officer or refer to www.greatwestlife.com.

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 authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member's Signature _____

Date _____

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

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