Assumption Life

P.O. Box 160/770, Main Street, Moncton, N.B. Canada E1C 8L1
Tel.: 506 853-6040 Fax.: 506 853-5434

Standard Dental Claim Form

PART 1 - DENTIST

Patient

Last Name Given Name

Address Apt

City Province Postal Code

Unique No. | Spec | Patient's Office Account No.

Dentist

Phone No. License 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 additionnal 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.

Signature of Patient / Parent / Guardian

Office Verification

Date of Service D	M	Y	Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	Total Charges

This is an accurate statement of services performed and the total fee due and payable E & OE.

Dentist's Signature | Date (Day, Month, Year) | Total Fee Submitted

For Carrier Use

Allowed Amount	Inc	Percentage	Patient's Share

Cheque No. | Date

Deductible | Patient Pays | Plan Pays

Claim No.

Instructions for Claim Submission

Being a standard form, this form cannot include specific instructions on where it should be sent depending on who is the carrier for your plan. You can obtain details from either your plan booklet, your certificate or from your employer. If your plan requires submission directly to the carrier, please send this form with only parts 1, 2 and 3 completed to the carrier's appropriate claims office. If your plan requires submission to your employer, please direct this form to your personnel office / plan administrator who will complete part 4 and forward the form to the carrier.

PART 2 - EMPLOYEE / PLAN MEMBER / SUBSCRIBER

Account No. | Employee No. | Employer | Name of Insuring Agency or Plan | Your Name (Please Print) | Your Date of Birth (D/M/Y)

PART 3 - PATIENT INFORMATION

1. Patient

Relationship to Employee Plan Member / Subscriber Date of Birth (D/M/Y)

If Child Indicate ☐ Student ☐ Handicapped

If Student Indicate School Patient ID No.

2. Are any dental benefits or services provided under any other group insurance or dental plan, W C B, or Government Plan?

☐ No ☐ Yes

Policy No. Spouse Date of Birth Name of Other Insuring Agency or Plan

3. Is any treatment required as the result of an accident? ☐ No ☐ Yes
If yes, give date and details separately.

4. If denture, crown or bridge, is this initial placement? ☐ No ☐ Yes
Give the date of prior placement and reason for replacement

5. Is any treatment required for orthodontic purposes? ☐ No ☐ Yes

6. 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.

Date (D/M/Y) Signature of Employee / Plan Member / Subscriber

PART 4 - POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF CLAIMS MUST BE SUBMITTED TO THE EMPLOYER)

	Day	Month	Year
1. Date Coverage Commenced			
2. Date Dependent Covered			
3. Date Terminated			

Date (D/M/Y) Authorized Signature

Position or Title

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL