STANDARD LIFE

Dental Claim Form

MONTRÉAL
P.O. BOX 4002,
POSTAL STATION B
MONTRÉAL, QUEBEC
H3B 4M2

TORONTO
P.O. BOX 4105,
POSTAL STATION A
TORONTO, ONT.
M5W 2P4

CALGARY
P.O. BOX 210
CALGARY, ALBERTA
T2P 4M6

QUÉBEC
P.O. BOX 8496
STE-FOY, QUEBEC
G1V 4N5

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PART 1 - DENTIST

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

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

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.						**TOTAL FEE SUBMITTED**		

IN THE CASE OF MAJOR SERVICES, please have your dentist complete the back of the form.

IN THE CASE OF DENTAL ACCIDENT, please complete "accidental injury" claim form.

PARTICIPANT'S STATEMENT (PART 1) please complete part 1 and 2.

NAME OF POLICYHOLDER

Participant's Name

Contract/Plan No.: Certificate No.: Social Insurance No.

Sex: M ❑ F ❑ Language : E ❑ F ❑ Date of birth: D D M M Y Y Y Y

PATIENT

Patient's Name Relationship to participant

If your child has reached the age limit specified in the contract, please complete below:

Sex: M ❑ F ❑ Student: Yes ❑ No ❑ Full time ❑ Part time ❑ Date of birth: D D M M Y Y Y Y

Name of the attended school From D D M M Y Y Y Y to D D M M Y Y Y Y

Telephone: (____) **Standard Life reserves the right to confirm the above information with the school attended.**

COORDINATION OF BENEFITS (PART 2)

With the coordination of benefits, you can obtain a reimbursement of up to 100% of your expenses. Is your spouse covered under an insurance plan with his/her employer?: **Yes** ❑ **No** ❑

If yes, please provide the following details:

Name of group dental care Contract/Plan No.:

Spouse's date of birth: D D M M Y Y Y Y Spouse's type of coverage: family ❑ single ❑

I authorize the release of any information or records requested in respect of this claim to the plan administrator, its agents or the policyholder. I certify that the information given is true, correct and complete to the best of my knowledge and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life will automatically reject a part of this claim. A photocopy of this authorization is as valid as the original. I agree to the use of my social insurance number as my identification number in the Standard Life data base.

Signature of participant Date: Telephone: (____)

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REMOVABLE PROTHESIS

Is this an initial placement? Yes ❑ No ❑

If yes, indicate the extraction date for the replaced teeth. D D M M Y Y Y Y

In the case of a replacement, please indicate:

A. The date of prior placement: D D M M Y Y Y Y

B. The reason for replacement: ______

FIXED BRIDGES

Please forward pre-treatment panoramic or bitewing x-rays of left and right side.

If this is an initial placement, please indicate:

A. The extraction date of the replaced tooth/teeth: D D M M Y Y Y Y

B. The date of prior placement, if a removable partial denture is replaced by the bridge: D D M M Y Y Y Y

C. Indicate all missing teeth: ______

If this is a replacement, please indicate:

A. The date of prior placement: D D M M Y Y Y Y

B. The reason for replacement: ______

CROWNS, VENEERS, ONLAYS

Please forward periapical X-Ray of the tooth taken prior to the treatment.

Is this the initial placement? Yes ❑ No ❑

A. The date of prior placement: D D M M Y Y Y Y

B. The reason for replacement: ______

C. Pertinent details concerning the treatment: ______

DENTIST

Dentist's signature ______ Date D D M M Y Y Y Y