

STANDARD DENTAL CLAIM FORM





											F	rease p		IIQUI	F No	0		SPE	-C	$\overline{}$	PATIEN	JT'S OFFICE ACCOUNT NO	I HEREBY ASSIGN MY BENEFITS		
	P LAST NAME GIVEN NAME D																				. / (TO GITTOL AGGGGINT NO.	PAYABLE FROM THIS CLAIM TO THE		
A T	LAST	NAME									GIVE	N NAME	E	NAMED DENTIST AND AUTH PAYMENT DIRECTLY TO HIM/HEI								PAYMENT DIRECTLY TO HIM/HER.			
I '	I ADDRESS APT. T																								
	N CITY PROV. POSTAL CODE S																								
														T PHONE NO. SIGNATURE OF SUBSCRIBER UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY											
PROCEDURES, OR SPECIAL CONSIDERATION.													PL	PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.											
I A														ACKNOWLEDGE THAT THE TOTAL FEE OF \$											
															MARGED TO ME FOR SERVICES RENDERED. AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED										
																						SO AUTHORIZE THE COMMU CRIBED IN THIS FORM TO TH			
sic													SIC	GIGNATURE OF PATIENT (PARENT/GUARDIAN)											
DUPLICATE FORM ☐ OF													OF	DFFICE VERIFICATION											
		FOF SERVICE PROCEDURE INTL.TOOTH TOOTH DENTIST'S CODE SURFACES FEE										LABORATORY CHARGE TOTAL CHAR							IAF	RGES	INS	STRUCTIONS			
DAY	MO.	YH.	+	Τ	ODE			CODE	SURFACES	FEE				CHARGE								All claims under this group benefits plan are submitted throug the plan member. We may exchange personal informatio			
	+	+	+	+	\vdash							+	+	Н	H		Н	Н		+	-	about claims with the pl	an member and a person acting on eccessary to confirm eligibility and to		
		+				Н												Н		+		mutually manage the clai	ms.		
	+	+	+	+	\vdash					\vdash		-	+	Н			Н	Н	\perp	+		Have your dentist com Employee completes F	arts 2 and 3.		
	+	+	+	+	\vdash			+		\vdash	+	_	+		H		Н	Н	_	+		assignment portion of	be paid directly to the dentist, sign the Part 1 above. Assignment of benefits		
	+	+	+	+						\vdash	+	_	+				Н	Н	_	+		is irrevocable. Great-V	Vest Life may discuss details of this e.		
	+	+	+	+	\vdash					\vdash		_	+	Н			Н	Н	_	+		4. Send this claim to:			
	+	+	+	+		Н		+		\vdash			+		H		Н	Н	_	+		Questions? Call To	oll Free: 1.800.957.9777		
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	+	+	+	+	\vdash	Н				\vdash		+	+	Н			Н	Н	_	+		1			
	+	+	+			Н		+				+	+	Н	H		Н	Н		+		1			
THIS	THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.																Ш					For the deaf or hard of hearing: Toll Free: 1.800.990.6654			
AND	AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E. TOTAL FEE SUBMITTED																								
								ATION																	
Plan Number Division Number Employee Identification Number															umber										
Plan Name																									
Employee Name Date of birth / /															of birth/										
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At vo	Gre ur cl	at-W laim	est and	Lite ac	e, w Imii	re re niste	ecogn erina	ize an the ar	d respect oup benef	the 11 its p	mpor lan. I	tance of	ot p aoo	rıva / of	Cy. OU	Pers ır Pri	son: vac	al ir ov C	ntorn Buide	nati elin	ion th es. oi	at we collect will be use if vou have questions	ed for the purposes of assessing about our personal information		
																							about our personal information refer to www.greatwestlife.com.		
la	utho	rize	Gre	eat-	We	st L	ife, a	ny hea	althcare pr	ovid	er, m	y plan or serv	adr vice	nini nro	str	ator, Iers v	oth	er i kind	nsur	an	ce or	reinsurance companie: Vest Life located within	s, 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 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.															best of my knowledge.										
Employee's SignatureDate															e										
PART 3 COORDINATION OF BENEFITS																									
1.	Pat	ient'	s re	latio	ons	hip	to yo	u														2. Patient's date of	birth//		
3.	If th	ne pa	atie	nt is	а	child	d, doe	s the	patient res	ide v	vith y	ou?	Υe	es		No							Day Month Year		
4.	If th	ne ch	ild	is o	ver	18:	: a) l:	s he/sł	ne a full-tin	ne st	uder	ıt?	Υe	es		No									
							b) I	f stude	nt, how m	any l	nours	per w	eek	at	sch	nool?						_			
							c) Is	s he/sh	ne employe	ed?	□ Y	es [No) II	f ye	es, ho	ow i	maı	ny ho	our	s wor	ked per week?			
5.	a)	Are	yoı	or	any	oth/																Yes No			
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																						n? Yes No			
																						's Date of Birth /_	1		
6		-					,		esult of ar									۲۰۰		9	, , , , , , ,	Day	Month Year		
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