iA Financial Group

CLAIM FORM
DENTAL CARE

GROUP INSURANCE

Depending on your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Print

PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

Dentist (Last and first name/Address/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 to provide additional information, diagnosis, procedures, or special considerations:

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered.

Duplicate ☐ Predetermination ☐

Member's signature _____

Verification (Dentist) _____

Treatment and services rendered to the patient

DATE OF SERVICE Y	M	D	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEES	LABORATORY CHARGES	TOTAL CHARGES

Excluding any possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

Total fee submitted

PART 2: MEMBER'S STATEMENT

Policy no. | | | | | | | | | | | Policyholder's name _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y | | | | M | | D | | Sex: ☐M ☐F Language: ☐E ☐F

COORDINATION OF BENEFITS

IMPORTANT NOTE:

- *If one of your dependents is covered under another plan for dental care expenses, the expenses incurred by this dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.*
- *The expenses incurred by dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.*

Are you or your dependents covered by another group plan? ☐No ☐Yes Specify:

Name of insurance company _____ Policy no. _____ Coverage: ☐Individual ☐Family

Name of spouse or child _____ Date of birth Y | | | | M | | D | | |

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

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1. If expenses are incurred for a dependent, specify:

Last name _____ First name _____

Relationship to member _____ Date of birth Y M D

Children 18 and over: ☐ Handicapped ☐ Full-time student Name of school _____

2. If the claim is the result of an accident, specify: ☐ Work ☐ Motor vehicle ☐ Other
and complete the "Dental Care in Case of an Accident" form (F54-267A)

3. Is any treatment planned for orthodontic purposes? ☐ Yes ☐ No

4. For a denture, crown or bridge, is this an initial placement? ☐ Yes ☐ No IF YES, please submit pre-treatment x-rays.

IF NO, specify date of prior placement Y M D and the necessity for replacement: _____

_____

_____

5. For a fixed bridge, have you worn or do you currently wear a partial denture? ☐ Yes ☐ No

IF YES, specify date of last placement Y M D and the necessity for replacement: _____

_____

MEMBER CONFIRMATION/AUTHORIZATION

I HEREBY CONFIRM that the information contained in this claim form is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to this claim.

On behalf of myself and my dependents:

(1) I consent to the RELEASE of the information contained in this claim form to Industrial Alliance Insurance and Financial Services Inc. (the "Company"), its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and

(2) I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to the Company, its employees, agents and service providers any information regarding the treatment charges incurred which they may need in the assessment of the claim.

(3) I UNDERSTAND AND AUTHORIZE that in the event there is reasonable suspicion of or any evidence of fraud or abuse regarding the claim, the Company will have the right to use and exchange any information related to the claim with any relevant regulatory, investigative or government body, any healthcare provider or professional medical organization, insurance company or reinsurer, the policyholder, my employer or any other party as provided by law for the purpose of investigating any such fraud or abuse.

I UNDERSTAND that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

I AUTHORIZE the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** _____ Date Y M D

Address _____ Postal code

Home phone Work phone Ext.

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