CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. 69507250 | SPEC. Ortho | PATIENTS OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

DENTIST

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

PHONE NO. (613) 440-6116

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

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 CHARLES COHEN D.M.D., MS.D., F.R.C.D.(C)

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

NO CODES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	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 YOU 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

1. GROUP POLICY/PLAN NO._____DIVISION/SECTION NO._____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED
DAY MONTH YEAR

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE OR DENTAL PLAN, W.C.B. OR GOV'T 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? IF YES, GIVE DATE AND DETAILS SEPERATELY. ☐ NO ☐ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

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 _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER DATE _____
DAY MONTH YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

OTIP RAEO

Standard Dental Claim

SECTION 1: DENTIST INFORMATION

PATIENT

Last Name	Given Name	Unique No.	Spec	Patient's Office Acct. No.
		69507250	Ortho	

Address _____ Apt. _____

City _____ Prov. _____ Postal Code _____

DENTIST

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

(613) 440-6116

Phone No.

For Dentist's use only - For additional information, diagnosis, procedures, or special consideration.

I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.

SIGNATURE OF PLAN MEMBER ▶

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) ▶

☐ Duplicate Form

Office verification CHARLES COHEN D.M.D., MS.D., F.R.C.D.(C)

Date of Service DAY	MO.	YR.	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

NO CODES

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

TOTAL FEE SUBMITTED: $

☐ **CHECK HERE IF TREATMENT PLAN**

When a proposed course of treatment is expected to cost more than $500, a treatment plan must be filed with OTIP Benefits Services. You will be advised of the benefits payable under your plan before treatment begins. Pre-treatment x-rays are required for some procedures (e.g. crowns and bridges).

SECTION 2: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)

OTIP Identification Number	Plan Number	Date of Birth *(mm/dd/yyyy)*

Plan Sponsor	Email Address

Direct Deposit

Receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Visit www.otip.com and log in. Once you have logged in to the Plan Member Secure Site (also known as 'My Claims'), choose **My profile** from the top navigation, then **Update banking information.** First-time users, you will need to complete registration.

SECTION 3: PATIENT INFORMATION

1. Patient: Relationship to Plan Member _____ Date of Birth *(mm/dd/yyyy)* _____

   If Child, indicate: ☐ Student ☐ Handicapped If Student, Indicate School _____

2. Are any dental benefits or services provided under any other group insurance or dental plan? ☐ Yes ☐ No
   Any type of workers' compensation board or government plan?

   Plan Contract Number _____ Name of Insurance Company _____

   Spouse Date of Birth *(mm/dd/yyyy)* _____

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

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

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

SECTION 4: CERTIFICATION AND AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. I authorize OTIP and the group benefits insurance carrier ("Insurer") that provides my benefits coverage to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

Signature of Plan Member **Date** *(mm/dd/yyyy)*

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file.

Access to your Information will be limited to:

- The Insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

SECTION 5: MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

OTIP Dental Claims
PO Box 280
Waterloo ON N2J 4A7

QUESTIONS?

OTIP Benefits Services
1-866-783-6847

canada life

STANDARD DENTAL CLAIM FORM

Please print

CANADIAN DENTAL ASSOCIATION

CLHIA ACCAP

PART 1 DENTIST

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

UNIQUE NO. 69507250 | SPEC. Ortho | PATIENT'S OFFICE ACCOUNT NO.

DENTIST

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

PHONE NO. (613) 440-6116

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST.

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 CHARLES COHEN D.M.D., M.S.D., F.R.C.D.(C)

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL.TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

NO CODES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on their behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Canada Life may discuss details of this claim with the assignee.
4. Send this claim to:

Questions? Call Toll Free: 1-800-957-9777

Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

www.canadalife.com

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us: TTY to Voice: 711
Voice to TTY: 1-800-855-0511

PART 2 EMPLOYEE INFORMATION

Plan Number _____ Division Number _____ Employee Identification Number _____

Plan Name _____

Employee Name _____ Date of birth ____/_____/_____ (Day / Month / Year)

Employee address _____

At Canada 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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

I authorize Canada 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 Canada 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.

Employee's Signature _____ Date _____

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you _____ 2. Patient's date of birth ____/_____/_____ (Day / Month / Year)
3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
4. If the child is over 18: a) Is the dependent a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Is the dependent employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____
5. a) Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy Number _____
   b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/_____/_____ (Day / Month / Year)
6. Is this treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, give date, location, and explain how accident happened _____
7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement.

_____

Dental Claim Form

Approved by the Canadian Dental Association

Sun Life Financial

1 To be completed by Dentist

PATIENT

Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

DENTIST

Unique Number: 69507250 | Spec.: Ortho | Patient's Office Account No.

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

Phone No.: (613) 440-6116

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 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/Dentist's Signature CHARLES COHEN D.M.D., M.S.D., F.R.C.D.(C)

Date of Service Day	Month	Year	Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

NO CODES

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

TOTAL FEE SUBMITTED

For Plan Administrator Use Only

2 Information about you – *be sure to fully complete this section*

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence ☐ English ☐ French

Your last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)	Daytime phone number
			– –	– –

Your address (street number and name)	Apartment or suite	City	Province	Postal code

3 Spouse and children covered by this claim – *complete this section if claim is for spouse or child*

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	☐ Male ☐ Female
		– –	

Child's name	Relationship to you ☐ Son ☐ Daughter	Date of birth (yyyy-mm-dd)	Complete for overage dependents (refer to benefit information for age limits) ☐ Disabled ☐ Full-time student
		– –	

4 Co-ordination of benefits – *complete this section if your spouse and/or children has coverage under any other dental plan or contract*

Is your spouse or are your children covered for any of these expenses under any other dental plan or contract? ☐ No ☐ Yes

If yes,:
- You must submit a claim for your spouse to his/her plan first.
- You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year.

If your spouse's plan is also with us, complete the following:

Contract number	Member ID number	Spouse's date of birth (yyyy-mm-dd)	Do you want us to co-ordinate benefits (process both claims)? ☐ No ☐ Yes
		– –	

If yes, spouse's signature	Date (yyyy-mm-dd)
X	– –

For SLF use:
DCF

5 Details of claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

1. Are any expenses the result of an accident? ☐ No ☐ Yes If yes, complete the following:

When did the accident occur? (yyyy-mm-dd)	Where did the accident occur?	How did the accident occur?
– –	☐ Work ☐ Home ☐ Other	
Are any expenses the result of a condition covered by a workers' compensation program? ☐ No ☐ Yes		

2. Is this treatment for orthodontic purposes? ☐ No ☐ Yes Implants? ☐ No ☐ Yes

3. Crowns, Bridges, Dentures Is this the initial placement? ☐ No ☐ Yes

If No, date of prior placement (yyyy-mm-dd)	Reason for replacement	If Yes, date teeth were extracted (for denture or bridge) (yyyy-mm-dd)
– –		– –

Please include the following to facilitate handling of your claim:

- Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays)
- List of all missing teeth (for bridges only)

6 Authorization and signature – *you must complete this section*

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada ("Sun Life") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

Member's signature	Date (yyyy-mm-dd)
X	– –

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Questions? Please visit **www.sunlife.ca** or call our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – *keep a copy of your claim form and receipts for your records*

Mail your completed form to the claims office nearest you.

Sun Life Assurance Company of Canada
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6

For SLF use:
DCF

Manulife

Group Benefits
Dental Claim

PART 1 - DENTIST

PATIENT			DENTIST	
LAST NAME	GIVEN NAME	UNIQUE NO. 69507250	SPEC. Ortho	PATIENT'S OFFICE ACCT. NO.
ADDRESS	APT.	Dr. Charles Cohen 240 Kennevale Drive, Suite 204 Nepean, ON K2J 6B6		
CITY	PROV. POSTAL CODE	PHONE NO. (613) 440-6116		

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

☐ DUPLICATE FORM

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF PLAN MEMBER ▶

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 CHARLES COHEN D.M.D., MS.D., F.R.C.D.(C)

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

NO CODES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED: $

☐ **CHECK HERE IF TREATMENT PLAN**

WHEN A PROPOSED COURSE OF TREATMENT IS EXPECTED TO COST MORE THAN $500, A TREATMENT PLAN MUST BE FILED WITH MANULIFE GROUP BENEFITS. YOU WILL BE ADVISED OF THE BENEFITS PAYABLE UNDER THE GROUP PLAN **BEFORE** TREATMENT BEGINS. PRE-TREATMENT X-RAYS ARE REQUIRED FOR SOME PROCEDURES (E.G. CROWNS, DENTURES, BRIDGES, AND IMPLANTS).

PART 2 - PLAN MEMBER INFORMATION

1. PLAN CONTRACT NUMBER _____
   PLAN SPONSOR _____
   NAME OF INSURANCE COMPANY **Manulife**

2. PLAN MEMBER NAME (PLEASE PRINT) _____
   PLAN MEMBER CERTIFICATE NUMBER _____
   DATE OF BIRTH (DD/MMM/YYYY) _____
   DAYTIME PHONE NUMBER ( ) _____

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO PLAN MEMBER _____
   DATE OF BIRTH (DD/MMM/YYYY) _____
   IF CHILD, INDICATE ☐ STUDENT ☐ HANDICAPPED
   IF STUDENT, INDICATE SCHOOL _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, DENTAL OR GOV'T PLAN? ☐ NO ☐ YES
   SPOUSE DATE OF BIRTH (DD/MMM/YYYY) _____
   NAME OF INSURANCE COMPANY _____
   IF MANULIFE, PLAN CONTRACT NUMBER _____
   CERTIFICATE NUMBER _____

ARE ANY OF THE EXPENSES ASSOCIATED WITH A WORK RELATED INCIDENT AND ELIGIBLE FOR WORKERS COMPENSATION BENEFITS? ☐ NO ☐ YES
IF YES, SUBMIT THESE EXPENSES TO YOUR PROVINCIAL WORKERS COMPENSATION BOARD.

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
   IF YES, GIVE DATE AND DETAILS SEPARATELY.

4. IF DENTURE, CROWN, BRIDGE, OR IMPLANT PLEASE INCLUDE PRE-TREATMENT X-RAYS AND LIST ALL MISSING TEETH.
   IS THIS THE INITIAL PLACEMENT? ☐ NO ☐ YES
   IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.
   IF YES, GIVE DATE TEETH WERE EXTRACTED.

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

Please complete both pages of this form.

PART 4 - BANKING INFORMATION AND EMAIL ADDRESS

Visit **manulife.ca/planmember** to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile menu OR complete this section.

Complete **only** when providing new or updated information.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.

By providing your email address, you will receive an email notification once your claim has been processed, including a link to **manulife.ca**, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit **manulife.ca/planmember** to register for your Plan Member secure site.

Email address (Please print clearly)

PART 5 - AUTHORIZATION AND CONSENT

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. **I understand and acknowledge** that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. **I understand and acknowledge** that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim submission. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers, for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). **I agree** that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

I agree to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and **I authorize** Manulife to deduct such monies from my future claims. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Manulife's Privacy Policy is available at manulife.ca/groupbenefits, or from my Plan Sponsor.

If applicable, **I authorize** Manulife to deposit all payments due to me from the above-referenced Group Benefits Plan ("Payments") into the bank account ("Account") that I have identified on this form. **I confirm** that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or by my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). **I also understand and agree** that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s) requested herein and require my personal written endorsement relating to future Payment(s). **I also hereby acknowledge and agree** that any Payment(s) made by Manulife into the Account to which I am not entitled, either by contract or by law, shall not form part of my property and shall be immediately refunded to Manulife, either by me, by my duly authorized representatives or by representatives of my estate.

If applicable, **I authorize** Manulife to use the email address provided as a means of communication with me related to my group benefits. **I agree** that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. **I agree** that should the email address identified on this form change, I am responsible for updating the email address maintained by Manulife. **I understand** that if I do not wish to receive emails from Manulife, I can unsubscribe, remove my email address online or contact the Customer Service Centre at 1-800-268-6195 to have my email address removed.

I understand that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

PLEASE SIGN HERE

Signature of plan member _____ Date signed (dd/mmm/yyyy)_____

PART 6 - MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec:
Manulife Group Benefits
Dental Claims
PO BOX 1654
WATERLOO ON N2J 4W2

If you live in Quebec:
Manulife Group Benefits
Dental Claims
PO BOX 5000, STN B
MONTREAL QC H3B 4B5

DENTAL EXPENSE CLAIM FORM

SECTION 1 - TO BE COMPLETED BY DENTIST

PATIENT

Last name	First name	
Mailing address		
City	Province	Postal Code

DENTIST

Unique No.	Spec.	Patient's office account no.
69507250	Ortho	

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6
Phone number (613) 440-6116

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

_____
Signature of plan member

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 policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the 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 insurance company/plan administrator.

Signature of patient (Parent/Guardian) _____

Office verification / Dentist's signature CHARLES COHEN D.M.D., M.S.D., F.R.C.D.(C) _____

Date of service yyyy	mm	dd	Procedure code	Int. tooth code	Tooth surfaces or units	Dentist's fee	Laboratory charge	Total charges

NO CODES

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

TOTAL FEE SUBMITTED

Return completed form to Coughlin for processing

COUGHLIN
employee benefits specialists

Tel: 613-231-8540 / 1-877-768-3378
Fax: 613-231-6180
E-mail: ottclaims@coughlin.ca

Mailing address
PO Box 3517 Station C
Ottawa, ON K1Y 4H5

Street address
466 Tremblay Road
Ottawa, ON K1G 3R1

SECTION 2 - TO BE COMPLETED BY PLAN MEMBER

Plan sponsor/Group name			Member ID/PIN	
Member last name	Member first name	Member middle initial	Sex ☐ Male ☐ Female	Date of birth (yyyy/mm/dd)
Mailing address		City	Province	Postal code
Email address	Primary telephone	Secondary telephone	Language of correspondence	☐ English ☐ French

SPOUSE OR DEPENDANT INFORMATION Complete only if claim is for a dependant

Last name	First name	Date of birth (yyyy/mm/dd)	Sex	Full-time student	Disabled child	Relationship to plan member
			☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No	

COORDINATION OF BENEFITS How to submit a claim when there are two plans

- Send your claims to your own plan first. When you receive your explanation of benefits, send it along with copies of your receipts to your spouse's plan to claim any unpaid amount.
- Send your spouse's claims to their plan first, then send a copy of their explanation of benefits and receipts to your plan.
- Send your children's claims first to the plan of the parent whose birthday (month and day) occurs first in the calendar year.

Are any of the expenses associated with a work related incident AND eligible for workers' compensation benefits? ☐ Yes ☐ No
If yes, submit these expenses to your provincial workers' compensation board.

Are any dental services provided under any other group insurance or health plan or government plan? ☐ Yes ☐ No
If yes, who is the member of this other plan? Name _____ Date of birth (yyyy/mm/dd)_____ Relationship to plan member _____

If your other benefit plan is with Coughlin, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No If yes, complete the following:

Plan sponsor/Group name	Last name	First name	Member ID/PIN	Signature

CLAIM INFORMATION

1. Is this claim due to an accident? ☐ Yes ☐ No If yes, date of accident (yyyy/mm/dd) _____ Ensure to attach the details of the accident
2. Does the treatment involve the placement of a crown / bridge or denture? ☐ Yes ☐ No
   If yes, is this the initial placement? ☐ Yes ☐ No UPPER ☐ Yes ☐ No LOWER ☐ Yes ☐ No
   If no, provide the date of prior placement and attach an explanation (yyyy/mm/dd) _____

HEALTH CARE SPENDING ACCOUNT Complete only if you have this benefit

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Care Spending Account (HCSA). I understand that I must first submit my claim using the co-ordination of benefits with my spouse's plan, if applicable.

☐ I do not wish to use my HCSA ☐ I wish to use my HCSA to cover the expenses that are not reimbursed under my group insurance plan

AUTHORIZATION & DECLARATION

I authorize Coughlin & Associates Ltd. ("Coughlin") to collect, use, maintain and disclose my personal information with the following persons, organizations or parties: health care providers; companies affiliated with Coughlin; financial institutions; government agencies; insurance companies and their reinsurers and/or service providers; employers or former employers; my local union; plan trustees and auditors for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility (as applicable). When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this form is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member signature	Date (yyyy/mm/dd)

Protecting your personal information: Coughlin recognizes and respects every individual's right to privacy. We are committed to keeping personal information private, confidential, accurate and secure. When personal information is provided to us, we establish a confidential file that is kept in our office, or the office of an organization authorized by us. Personal information is kept in a secure environment. We limit access to personal information in your file to Coughlin staff or persons authorized by Coughlin who require access to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to administer the plan. You may exercise certain rights of access to the personal information in your file, and where appropriate, to have inaccurate information corrected by sending a written request to Coughlin. For information on our Privacy Policy, visit our website at www.coughlin.ca, or send a written request to our Privacy Officer by mail or by email at privacy@coughlin.ca.

ONTARIO BLUE CROSS™

P.O. BOX 4433, STATION A
TORONTO (ONTARIO) M5W 3Y7

canadian Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. 69507250 | SPEC Ortho | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____

POSTAL CODE _____

DENTIST

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

PHONE NO. (613) 440-6116

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 RESPONSABLE 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 CHARLES COHEN D.M.D., MS.D., F.R.C.D.(C)

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

NO CODES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	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

1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____
   EMPLOYER _____
   NAME OF INSURING AGENCY OR PLAN _____
2. YOUR NAME (PLEASE PRINT) _____
   YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____
   YOUR DATE OF BIRTH _____ (DAY MO. YR.)

PART 3 - PATIENT INFORMATION

1. RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____
   DATE OF BIRTH _____ (DAY MO. YR.) IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐
   IF STUDENT, INDICATE SCHOOL _____
   PATIENT I.D. NO. _____
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO ☐ YES ☐
   POLICY NO. _____ SPOUSE DATE OF BIRTH _____ (DAY MO. YR.)
   NAME OF OTHER INSURING AGENCY OR PLAN _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO ☐ YES ☐
4. IF TREATMENT INCLUDES DENTURE, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT? IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. NO ☐ YES ☐
   _____ (DAY MO. YR.)
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: _____ (DAY MO. YR.) _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)

PART 4 - POLICYHOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MO.	YR.
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER	DATE		
	DAY	MO.	YR.

_____ AUTHORIZED SIGNATURE

_____ (POSITION OR TITLE)

STANDARD DENTAL CLAIM FORM

Approved by the Canadian Dental Association

Empire Life

PART 1 DENTIST

UNIQUE NO. 69507250 | SPEC. Ortho | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

Dr. Charles Cohen
240 Kennevale Drive, Suite 204
Nepean, ON K2J 6B6

PHONE NO 613-440-6116

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/DENTIST'S SIGNATURE

CHARLES COHEN
D.M.D., M.S.D., F.R.C.D.(C)

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INT'L. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

NO CODES

We strongly recommend that if charges will be $300.00 or more your claim be submitted for predetermination of benefits before the work is started. The submission of x-rays will be required for crowns or bridgework. These will be returned promptly to your dentist.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE.

TOTAL FEE SUBMITTED

PART 2 INSURED/SUBSCRIBER

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

Group Policy No. _____ Division No. _____ Employer _____

Cert. No. _____ Name of Subscriber _____

Patient: relationship to Subscriber _____ Date of Birth _____
If child, is he/she employed? No ☐ Yes ☐ - Where? _____ # Hrs. Worked _____
Is he/she wholly dependent on you for support? No ☐ Yes ☐
If child age 21 or over, indicate Student: Full time ☐ Part time ☐ if Handicapped ☐
If student, indicate school _____
Are any dental benefits or services provided under any other Group
Insurance or Dental Plan? No ☐ Yes ☐ Policy No. _____

Name of Insuring Agency _____

If yes, provide spouse's Date of Birth _____

and Subscriber's Date of Birth _____

If denture, crown or bridge, is this initial placement? No ☐ Yes ☐ Give date of prior placement and reason for replacement
Is any treatment required as the result of an accident? No ☐ Yes ☐ Give date and details
Is any treatment for orthodontic purposes? No ☐ Yes ☐ Is claim being made for Workers' Compensation Benefits? No ☐ Yes ☐

I certify that the statements above are complete and true and that all attached receipts represent no duplication of charges previously submitted.

I authorize:

1. The release of full information and records with respect to this claim to The Empire Life Insurance Company (Empire Life) and I authorize Empire Life, its agents, representatives or consultants to collect and review this information (as deemed necessary) for the purpose of reviewing , assessing and managing this claim;
2. Empire Life to release to the policyholder/plan administrator and agent of record any group statistical information that may include information concerning claims paid on my behalf or on behalf of my eligible dependants (other than specific details relating to medical condition(s)) for the purpose of negotiating policy renewals, premiums and benefits management;
3. Empire Life to reimburse the insured plan member directly with respect to this claim.

I agree a photocopy of this authorization shall be as valid as the original.
I understand all claims made under this Group Plan are submitted through the insured plan member. Empire Life may exchange information about these claims with the insured plan member or any person acting on his or her behalf (as deemed necessary) for the purpose of confirming eligibility and assessing and managing the claim.

Date: _____ Signature of Claimant: _____

SEE REVERSE FOR MORE INFORMATION