Assumption Life
Group Insurance

Reset

Standard Dental Claim Form

Section 1 To be Completed by the Dentist

Patient

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Unique No. | **Spec.**

Dentist

Telephone _____ License No. _____

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 _____

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 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 fees of $_____ are accurate and have been charged to me for services rendered. I authorize release of the information contained in this claim form to my insurer.

Signature of Patient /Parent/ Guardian _____ Office Verification _____

Date of Service DD	MM	YYYY	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 fees due and payable.

Dentist's Signature _____ Date (DD/MM/YYYY) _____ Total Fees Submitted _____

Section 2 To be Completed by the Employee

First Name _____ Last Name _____ Date of Birth (DD/MM/YYYY) ____/____/_____ Policy _____ Division _____ Certificate _____

Address _____ City _____ Province _____ Postal Code _____

Section 3 Coordination of Benefits (if you do not have a spouse, this section does not apply)

Does your spouse have dental coverage under his/her own insurance plan? ☐ Yes ☐ No

Effective Date ____/____/_____ DD MM YYYY

If yes, is the health coverage: ☐ An individual plan ☐ A family plan

Spouse's Name _____ Name of Other Insurer _____ Contract Number _____

Please also attach a copy a copy of the detailed summary of benefits.

Section 4 Claim Details

1. Is any treatment required as the result of an accident? ☐Yes ☐No
   If yes, give date and details on a separate page.
2. If denture, crown or bridge, is this the initial placement? ☐Yes ☐No
   If no, give the date of prior placement, a list of missing teeth and reason for replacement.

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, accurate and complete to the best of my knowledge.

Employee's Signature _____ Date (DD/MM/YYYY) _____

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