## STANDARD DENTAL CLAIM FORM

**Approved by the Canadian Dental Association**

## PART 1 DENTIST

UNIQUE NO. | SPEC. | 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

PHONE NO

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

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

In order to obtain prompt payment of your claim, did you…

Complete and sign your claim form?
Include your correct current address and postal code?
Include a copy of the Explanation of Benefits from your other insurance company if co-ordinating benefits?

If assigning payment directly to your dentist, please ensure that the assignment portion of the Dental Claim Form is completed.

Empire Life reserves the right to ask for additional information in order to assess this or any future claims.

Claims submitted more than 365 days from the date of service or more than 90 days after termination of coverage will be declined as too late to allow.

When Completed, Please Mail Your Claim Form To:

The Empire Life Insurance Company
Group Health Claims
259 King Street East
Kingston ON
K7L 3A8

Your claim payment will be sent to the address on the claim form.
Missing or incorrect information results in unavoidable delays in claims payment.

Take advantage of automatic payments deposited to your bank account via EFT (electronic funds transfer).
To begin receiving your dental claim payments by this method simply attach a void cheque to this claim form.

Insurance Fraud
Insurance Fraud is an intentional act or omission with a view to illegally obtaining an insurance benefit.
Fraudulent claims increase the cost of your group insurance.

Group Customer Service Unit 1-800-267-0215