Dental claim form for Personal Health Insurance

Sun Life Financial

Approved by the Canadian Dental Association

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Dentist

PATIENT

Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

DENTIST

Unique Number | Spec. | Patient's Office Account No.

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 - 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.

Signature of Patient (Parent/Guardian)

Office Verification/Dentist's Signature

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

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

TOTAL FEE SUBMITTED

For Administration Use Only

2 To be completed by Policyowner

You must complete this section.

Policyowner Information

Policy Number	ID N°	Date of Birth (d/m/y)
37000		

Last Name | Given Name ☐ Male ☐ Female

Street Address | Daytime Telephone Number ( )

City | Province | Postal Code | Evening Telephone Number ( )

3 Spouse and Children Covered by this Claim

Complete only if claim is for your spouse or child.

Spouse's Full Name ☐ Male ☐ Female | Date of Birth (d/m/y)

Child's Name	Relationship to you		Date of Birth			Complete for overage dependants (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	☐	☐				☐	☐

4 Details of Claim

If your dentist has recommended crowns and/or bridgework, or any other dental expense over $500.00 (per patient), please have your dentist complete a pre-treatment plan and submit it to us before treatment begins.

1. Are any expenses the result of an accident? No ☐ Yes ☐▶		If yes, complete the following:
When and where did the accident occur (d/m/y): _____	Work ☐ Home ☐ Other ☐	
How did the accident occur?		
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 (d/m/y): _____ • Reason for replacement: _____		If Yes, • Date teeth were extracted (for denture or bridge (d/m/y): _____
Please include the following to facilitate handling of your claim:	• Pre-treatment x-rays (for crowns, bridges, veneer, inlays, onlays) • List of all missing teeth (for bridges only)	

5 Authorization and Signature

You must complete this section.

Fraudulent claims are very costly for all participants in benefit plans. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

I certify that all goods or services being claimed have been received by me/my dependants. If this claim is being made on behalf of my spouse and/or dependants, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any.

I certify that the information in this form is true and complete and does not contain a claim for any expenses previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its advisors and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event that this plan is audited.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Policyowner's signature	Date (d/m/y)
X	

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

For details specific to your plan, consult your Policy or call 1 877 SUN-LIFE (1 877 786-5433)

Mail the completed form to:

Sun Life Assurance Company of Canada
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1