

# Dental Claim Form



Approved by the Canadian Dental Association



## 1 To be completed by Dentist

P A T I E N T  Last Name _____ Given Name _____ Address _____ Apt. _____ City _____ Prov. _____ Postal Code _____	Unique Number _____ Spec. _____ Patient's Office Account No. _____ D E N T I S T  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 <input type="checkbox"/>		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 _____		<b>For Plan Administrator Use Only</b>					
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			

## 2 Information about you - be sure to fully complete this section

Contract number 50177	Member ID number	Your plan sponsor/employer The Canadian Chiropractic Association	Preferred language of correspondence <input type="checkbox"/> English <input type="checkbox"/> French
Your last name	First name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (d/m/y) _____ 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 (d/m/y) _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's name	Relationship to you	Date of birth	Complete for coverage dependents (refer to benefit information for age limits)
	Son    Daughter	Day    Month    Year	Disabled    Full-time student
	<input type="checkbox"/> <input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/>

## 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 and/or children covered for any of these expenses under any other dental plan or contract? No  Yes  Spouse's date of birth (d/m/y): \_\_\_\_\_

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: Contract number: \_\_\_\_\_ Member ID number: \_\_\_\_\_

Do you want us to co-ordinate benefits (process both claims)? No  Yes  If yes, spouse's signature: X \_\_\_\_\_ Date (d/m/y) \_\_\_\_\_

## 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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/>		If yes, complete the following:	
When and where did the accident occur (d/m/y): _____		Work <input type="checkbox"/>	Home <input type="checkbox"/> Other <input type="checkbox"/>
How did the accident occur? _____			
Are any expenses the result of a condition covered by a workers' compensation program? No <input type="checkbox"/> Yes <input type="checkbox"/>			
2. Is this treatment for orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>		Implants? No <input type="checkbox"/> Yes <input type="checkbox"/>	
3. Crowns, Bridges, Dentures		Is this the initial placement? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If No, • Date of prior placement (d/m/y): _____		If Yes, • Date teeth were extracted _____	
• Reason for replacement: _____		(for denture or bridge (d/m/y): _____)	
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 use and exchange information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan with 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 exchange of information about this claim with 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 X	Date (d/m/y)
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### Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

**Questions?** Please visit [www.sunlife.ca](http://www.sunlife.ca) or call 1- 800-361-6212 Monday – Friday, 8 a.m. – 8 p.m. ET

Please retain a copy of your claim form and receipts for your records.

### Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims office:

Sun Life Assurance Company of Canada

PO Box 6076 Stn CV  
Montreal QC H3C 4S3

Sun Life Assurance Company of Canada

PO Box 3417 Stn D  
Ottawa ON K1P 1G1

Sun Life Assurance Company of Canada

PO Box 2880 Stn Main  
Edmonton AB T5J 4S6