Dental Claim Form

Approved by the Canadian Dental Association

Sun Life Financial

Clear

1 To be completed by Dentist

PATIENT				DENTIST		
Last Name	Given Name		Unique Number	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.
Address	Apt.					
City	Prov.	Postal Code	Phone No.:			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 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
50176		L'Association des médecins d'urgence du Québec	☐ English ☐ French

Your last name	First name	☐ Male ☐ 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)	☐ Male ☐ Female

Child's name	Relationship to you		Date of birth			Complete for overage dependents (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	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 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 ☐ 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): _____ 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	Date (d/m/y)
X	

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** 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