THE Great-West Life ASSURANCE COMPANY

THE REGIONAL MUNICIPALITY OF PEEL
MANDATORY DENTAL BENEFITS
FOR DEPENDENT CHILDREN - PLAN NO. 51607
DISCRETIONARY EMERGENCY DENTAL/DENTURE BENEFITS
FOR ADULTS - PLAN NO. 51616

Canadian Dental Association

Canadian Life and Health Insurance Association

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

BENEFITS AUTOMATICALLY ASSIGNED

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 CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

NOT REQUIRED

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DATE OF SERVICE DAY	MO.	YR.	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

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

Toronto Benefit Payments
P.O. Box 4076 Stn A
Toronto ON M5W 3A3
1-800-461-6090 (416) 440-1348

PART 2 PARTICIPANT (HEAD OF HOUSEHOLD) INFORMATION - PATIENT INFORMATION

PLEASE PRINT PLAN NO. **51607 / 51616** HEAD OF HOUSEHOLD'S MEMBER ID NUMBER _____

PARTICIPANT'S LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: ____/____/____/ D M Y

PATIENT'S LAST NAME: _____ FIRST NAME: _____

(IF APPLICABLE)

PATIENT'S RELATIONSHIP TO PARTICIPANT _____ PATIENT'S DATE OF BIRTH: ____/____/____/ D M Y

DID YOU CONTACT THE OW DENTAL UNIT FOR VERIFICATION OF COVERAGE? ☐ YES ☐ NO VERIFICATION NUMBER_____

IS CLAIM FOR: ☐ OW MCSS CHILDREN'S PROGRAM OR ☐ EMERGENCY SERVICES/DENTURE PROGRAM FOR ADULTS

IS THIS SERVICE REQUIRED FOR ORTHODONTIC TREATMENT? ☐ YES ☐ NO

IS THIS PATIENT ENTITLED TO BENEFITS UNDER ANY OTHER GROUP INSURANCE? ☐ YES ☐ NO

IF YES, PLEASE HAVE PATIENT ADVISE POLICY NUMBER, IDENTIFICATION NUMBER, NAME AND ADDRESS OF INSURANCE CARRIER.

_____

PART 3 PATIENT/GUARDIAN

AUTHORIZATION MUST BE SIGNED BY THE PARTICIPANT/SPOUSE/GUARDIAN/DEPENDENTS 18 AND OVER FOR CLAIM TO BE PROCESSED.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge. I hereby certify that I received these services.

SIGNATURE: _____ DATE: _____

GENERAL INFORMATION

DISCRETIONARY DENTAL PROGRAM - EMERGENCY SERVICES AND DENTURE SERVICES

COVERAGE IS PROVIDED FOR THE SERVICES LISTED IN THE SCHEDULE OF COVERED DENTAL PROCEDURES WHEN THEY ARE REQUIRED TO TREAT A DENTAL EMERGENCY. EMERGENCY SERVICE IS DEFINED AS AN IMMEDIATE CIRCUMSTANCE WHERE THE PATIENT APPEARS IN IMMEDIATE SUFFERING, REQUIRES CARE AND IMMEDIATE APPROPRIATE TREATMENT IS INSTITUTED TO CORRECT THE PROBLEM.

COVERAGE IS PROVIDED FOR DENTURES, DENTURE REPAIRS AND RELINES AS LISTED IN THE SCHEDULE OF COVERED DENTURE PROCUEDURES. PRE-DETERMINATION OF TREATMENT IS REQUIRED UNDER THE DENTURE SERVICES PROGRAM FOR ALL DENTURE SERVICES LISTED.

BENEFITS WILL BE PAID DIRECTLY TO PROVIDER OF SERVICE.

CLAIM MUST BE RECEIVED WITHIN 90 DAYS OF DATE SERVICE RENDERED OTHERWISE NO BENEFITS WILL BE PAID.

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