Desjardins Financial Security™

P.O. Box 4358, STN A
Toronto ON M5W 3M3

CLAIM FOR DENTAL CARE EXPENSES

To expedite processing of your claim, please answer all questions.

DENTIST

Name
Address
City, Province
Postal code
Telephone

Member number:

Last name of patient | First name(s)

Date of birth YYYY-MM-DD

Relationship to the member ☐ Spouse ☐ Daughter ☐ Son

Date of treatment Year Month Day	Tooth No.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge

Total fee claimed: →

IMPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer application, inlay or denture, please see the reverse side. If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

This section is reserved for the dentist's diagnosis.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED.

Signature of dentist

Date

TO BE COMPLETED BY THE MEMBER

Policy or group or contract no. | Certificate no.

Member's Last Name and First Name | Sex ☐M ☐F | Date of birth YYYY-MM-DD

Number, Street, Apartment | City, Province | Postal Code

Name of group or policyholder or employer

Complete only if you are claiming expenses incurred for your dependent children aged 18 or 21 or older (depending on the policy). Remember to include the information for the period in which the expenses were incurred for your child.

Full-time Student ☐ Yes ☐ No From YYYY-MM-DD To YYYY-MM-DD

Name of Educational Institution Attended

IF GROUP IS SELF-ADMINISTERED, the administrator must complete this section before the member fills out the form

In force	Individual	YYYY-MM-DD
	Family	YYYY-MM-DD
	Other, specify	YYYY-MM-DD
Terminated		YYYY-MM-DD

Administrator's signature

Date

Is your spouse insured under another insurance contract that provides benefits for dental care? ☐ **Yes** ☐ **No**

If yes, is the coverage: ☐ individual ☐ family

EFFECTIVE DATE YYYY-MM-DD

TERMINATION DATE YYYY-MM-DD

Full name of spouse:

Date of birth YYYY-MM-DD

Name of insurer | Policy no. | Certificate no.

DIRECT DEPOSIT - This section need only be completed if this is your initial request for direct deposit or to make a change to your existing account information. Include specimen cheque marked "VOID" for first requests or changes only.

Name and address of the financial institution	Transit number	Account number

HEALTH SPENDING ACCOUNT - Complete this section if you have this coverage.

Should the portion of expenses not covered under your contract be applied against your health spending account? ☐ Yes ☐ No

If you or your dependent children are covered under your spouse's insurance plan, would you like the portion of expenses not paid under the basic plan to be automatically processed through the health spending account instead of submitting them for coordination to your spouse's insurer? ☐ Yes ☐ No

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him. I authorize my dentist to disclose all the information appearing on this form to my insurance company or to one of its agents.

Signature of member | Date

I understand that I am responsible for the total cost of the treatment. I authorize my dentist to disclose all the information appearing on this form to my insurance company or to one of its agents.

Signature of member | Date

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY THE MEMBER

Date of the accident: YYYY-MM-DD Location of the accident: _____

How did the accident occur?

_____

_____

If the claim is the result of a work injury or a motor vehicule accident please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

TO BE COMPLETED BY THE DENTIST

Preoperative X-rays are required for the study of dental care made necessary as the result of an accident. They will be returned to the attending dentist as soon as possible.

Is it an accidental injury to a healthy and natural tooth? ☐ Yes ☐ No

Diagnosis and clinical description prior to the accident: _____

_____

_____

CLAIM FOR A DENTURE, VENEER APPLICATION, CROWN OR INLAY

Please include a copy of the bill from the commercial lab with your claim. Also, except for denture, please send us the appropriate X-rays taken prior to the treatment and X-rays showing the left and right sides for fixed bridge.

Print the form