STANDARD LIFE

GROUP LIFE & HEALTH

Dental Claim Form

MONTRÉAL
P.O. BOX 4002,
POSTAL STATION B
MONTRÉAL, QUÉBEC
H3B 4M2

TORONTO
P.O. BOX 4105,
POSTAL STATION A
TORONTO, ONT.
M5W 2P4

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Dentist *(please print)*

Patient		Dentist		
Surname		Unique no.	Spec.	Patient's office account no.
Given name(s)				
Main residence address *(no., street)*	Apt.			
City		Telephone no. ( )		
Province	Postal code	For dentist's use only - for additional information, diagnosis, procedures, or special consideration.		
I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.				
Signature of subscriber		❑ 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. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of patient *(parent/guardian)*	Date *(YYYY/MM/DD)* / /	Office verification

Date of service *(YYYY/MM/DD)*	Procedure code	Intl. tooth code	Tooth surface	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**		

IN THE CASE OF MAJOR SERVICES, please have your dentist complete the back of the form.
IN THE CASE OF DENTAL ACCIDENT, please complete "accidental injury" claim form.

Participant's statement (part 1) *(please complete part 1 and 2)*

Policyholder name						
Participant surname			Given name(s)			
Contract/Plan no.	Certificate no.	Social Insurance Number	Language: ❑ English ❑ French	Gender: ❑ M ❑ F	Date of birth *(YYYY/MM/DD)* / /	

Patient

Patient name	Relationship to participant

If your child has reached the age limit specified in the contract, please complete below:

Student: ❑ Yes ❑ No ❑ Full time ❑ Part time	Name of the attended school		
		Attendance period	
Gender: ❑ M ❑ F / Date of birth *(YYYY/MM/DD)* / /		Start *(YYYY/MM/DD)* / /	End *(YYYY/MM/DD)* / /
			Telephone no. of institution ( )

The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.

Please see reverse >>

Coordination of benefits (part 2)

With the coordination of benefits, you can obtain a reimbursement of up to 100% of your expenses.
Is your spouse covered under an insurance plan with his/her employer? ❑ Yes ❑ No

If yes, please provide the following details:

Name of group dental care insurer	Contract/Plan no.

Spouse's type of coverage: ❑ Family ❑ Single	Spouse's date of birth (YYYY/MM/DD) / /

Signature of participant	Telephone no. ( )	Date (YYYY/MM/DD) / /

Removable prosthesis

Is this an initial placement? ❑ Yes ❑ No If yes, indicate the extraction date for the replaced teeth.	Date (YYYY/MM/DD) / /

In the case of a replacement, please indicate:

A. The date of prior placement:	Date (YYYY/MM/DD) / /

B. The reason for replacement: _____

Fixed bridges

Please forward pre-treatment panoramic or bitewing X-rays of left and right side. If this is an initial placement, please indicate:

A. The extraction date of the replaced tooth/teeth:	Date (YYYY/MM/DD) / /
B. The date of prior placement, if a removable partial denture is replaced by the bridge:	Date (YYYY/MM/DD) / /

C. Indicate all missing teeth:

If this is a replacement, please indicate:

A. The date of prior placement:	Date (YYYY/MM/DD) / /

B. The reason for replacement: _____

Crowns, veneers, onlays

Please forward periapical X-ray of the tooth taken prior to the treatment.	Is this the initial placement? ❑ Yes ❑ No

A. The date of prior placement:	Date (YYYY/MM/DD) / /

B. The reason for replacement: _____

C. Pertinent details concerning the treatment: _____

Dentist

Signature of dentist	Date (YYYY/MM/DD) / /