

## GROUP DENTAL CLAIM FORM

### CLAIMING INSTRUCTIONS

1. *This form is to be completed by the dental office (Part 1) and the employee (Part 2).*
2. *Assignment of Benefits is irrevocable.*
3. *Submission of diagnostic x-rays or study models (if appropriate) for review by our dental consultant may prevent delays in the processing of your claim.*

### PART 1 DENTIST

LAST NAME _____ GIVEN NAMES _____ P A T I E N T A D D R E S S _____ C I T Y _____ P R O V. _____ P O S T A L C O D E _____ _____	<b>D E N T I S T</b>	UNIQUE NO. _____ SPEC. _____ PATIENT ACCOUNT NO. _____	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.  SIGNATURE OF SUBSCRIBER _____
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FOR DENTIST USE ONLY FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION _____ _____ _____	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY OR ITS AGENTS.  SIGNATURE OF PATIENT (OR PARENT GUARDIAN) _____  OFFICE VERIFICATION _____
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									ADDITIONAL CLAIM INFORMATION	
DATE OF SERVICE			PROCEDURE	TOOTH	TOOTH	DENTIST	LAB	TOTAL		
DAY	MO	YR	CODE	CODE	SURFACE	FEE	CHARGE	CHARGE		
									1. Is any treatment required as the result of an accident? Y / N	
									- If "Yes", please have the Accidental Dental Questionnaire completed.	
									2. If Denture or Bridge, is this an initial placement? Y / N	
									- If "Yes", provide dates of extractions _____	
									- If "No", provide date of prior placement and reason for replacement: _____	
									3. If crown or onlay, is this an initial placement? Y / N	
									- If "No", provide date of prior placement and reason for replacement: _____	
									4. Is any treatment required for Orthodontic purposes? Y / N	
TOTAL FEE										
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED E. & OE.										
DENTIST SIGNATURE _____						DATE _____				

### PART 2 EMPLOYEE STATEMENT

GROUP NUMBER _____	EMPLOYER NAME _____	CERTIFICATE NUMBER _____
NAME _____		RELATIONSHIP TO PATIENT _____
ADDRESS (If different from above) _____		
(Street)	(City)	(Postal Code)
1. ARE YOU, YOUR SPOUSE OR DEPENDENTS ELIGIBLE FOR THE CLAIMED EXPENSES UNDER ANY OTHER PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No		
IF YES, NAME OF OTHER CARRIER _____ SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____		
(ATTACH COPY OF STATEMENT OF PAYMENT OR DENIAL FROM OTHER CARRIER) <span style="float: right;">(YY/MM/DD)</span>		

### PART 3 EMPLOYEE AUTHORIZATION

**Notice Concerning Personal Information**

You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintaining communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

*You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 200-191 Broadway, Winnipeg, MB R3C 3P1 or at [www.wawanesalife.com](http://www.wawanesalife.com).*

**Authorization**

I have read the above Notice Concerning Personal Information. I authorize the release of any information in respect of this claim to Wawanesa Life. I further certify that the information on this form is true and complete.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_