



STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

Form section for Part 1 Dentist, including fields for Patient Last Name, Patient Given Name, Unique No, Spec, Patient's Office Account No, Dentist Name, Dentist Phone No, and Signature of Subscriber.

Form section for Dentist's Use Only, including fields for diagnosis, procedures, and a grid for missing teeth (18-38).

Table with columns: Date of Service (Day, Mo, Yr), Procedure Code, Intl. Tooth Code, Tooth Surfaces, Dentist's Fee, Laboratory Charge, Total Charges.

TOTAL FEE SUBMITTED

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. E & OE

OFFICE VERIFICATION [X]

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) [X]

PART 3 EMPLOYER/POLICYHOLDER

COMPLETE IF EMPLOYER'S/POLICYHOLDER'S AUTHORIZATION REQUIRED

Form section for Part 3 Employer/Policyholder, including fields for Employment Date, Employee's Effective Date, Dependent's Effective Date, Termination Date, Retirement Date, Status (Single, Couple, Family), Signature of Authorized Official, and Date.

PART 2 EMPLOYEE STATEMENT (Please Print)

Form section for Part 2 Employee Statement, including fields for Group No., Account No., PID#, and Employers Name/Policyholder Name.

1. Employee's name [first initial last] Previous surname (if applicable) [last]

2. Employee's mailing address [Street City Prov. Postal Code]

3. Employee's date of birth [D M Y]

4. Is this your first employee benefits claim with The Co-operators? [] No [] Yes

5. Are you actively at work? [] No [] Yes If NO are you [] Disabled? [] Retired?

6. Are dental benefits payable for this claim from any other company or source? [] No [] Yes

If YES name company and source [] Spouse's date of birth [D M Y]

7. Is any treatment due to an accident? [] No [] Yes. If YES give dates and details on separate paper

8. Is any treatment for orthodontic purposes? [] No [] Yes

9. If treatment is for crowns, bridge or denture, complete the following questions.

Is this initial placement [] No [] Yes. If NO provide previous placement date [D M Y]

If initial denture or bridge, provide dates that teeth were extracted [D M Y]

10. Which family member are expenses for? [] employee [] spouse [] son [] daughter [] other (specify) []

if spouse or child complete the following information:

Dependent's date of birth [D M Y] Is dependent [] student [] handicapped [] other (specify) []

If patient is a student over the age 21, name of school [] Student status: [] Full-time [] Part-time [] Correspondence, enrolled in the semester starting [] (date) and ending [] (date). Will student be graduating at the end of the semester indicated? [] Yes [] No

I authorize the release of any information or records requested in respect of this claim and certify that the information given on Part 2 is true, correct and complete to the best of my knowledge.

Signature of Employee [X] Date []

INCOMPLETE INFORMATION WILL MEAN A DELAY IN THE PROCESSING OF THE CLAIM. PLEASE MAKE SURE EVERYTHING IS COMPLETE AND ACCURATE. RETURN COMPLETED FORM TO: GROUP DENTAL CLAIMS, THE CO-OPERATORS, 1920 COLLEGE AVE., REGINA, SASK., S4P 1C4