THE Great-West Life ASSURANCE COMPANY ADMINISTRATORS FOR:

CANADIAN FORCES RESERVE (CLASS A AND B SERVICE) DENTAL CARE PLAN

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

PART 1 DENTIST

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

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

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

PHONE NO.

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.

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

1. HAVE YOUR DENTIST COMPLETE PART 1.
2. COMPLETE ALL QUESTIONS IN PART 2.
3. **SUBMIT FORM TO UNIT FOR APPROVAL.**
4. **UNIT FORWARDS FORM TO:**

MEMBERS POSTED OUTSIDE CANADA:	Great-West Life Foreign Benefit Payments P.O. Box 6000 Winnipeg, Manitoba R3C 3A5
QUEBEC RESIDENTS OTHER THAN NATIONAL CAPITAL REGION	Great-West Life Place Bonaventure Suite 5800 800 de la Gauchetière St. W Montreal, Québec H5A 1B9
OTHER CANADIAN RESIDENTS:	Great-West Life Benefit Payments P.O. Box 6025, Station Main Winnipeg, Manitoba R3C 3C7

PART 2 MEMBER (please print)

1. Member's Name and Initials | Language Preference ☐ English ☐ French | Plan Number **5 5 9 9 9** | Member's Certificate No.

Member's Home Address

2. Relationship of patient to member | Patient's Date of Birth Day Month Year | Is the patient a handicapped dependent child age 21 or over? ☐ Yes ☐ No

3. If a dependent child between 21 & 25 years old, is he/she a full-time student? ☐ Yes ☐ No

Name of educational institution

4. If a common-law partner, has the relationship been established in accordance with QR & O article 1.075? ☐ Yes ☐ No

5. Are you or any of your dependants entitled to benefits as a member/employee under this plan or any other group plan? ☐ Yes ☐ No

NAME OF PERSON COVERED	POLICY NO. AND I.D. NO.	NAME OF DENTAL PLAN / OTHER INSURANCE CO.

6. If yes to question 5, and patient is a dependent child, give member's birthday (day/month): _____/_____/ and
birthday of spouse or common-law partner (day/month): _____/_____/

NOTE: MEMBERS ARE NOT ELIGIBLE IF COVERED BY ANOTHER DENTAL PLAN.

7. Is treatment required as the result of an accident? ☐ Yes ☐ No

If yes, give date, location, and explain how accident happened

If yes, are you a member of the Public Service Health Care Plan? (include copy of benefit payment from the Health Care Plan). ☐ Yes ☐ No

8. If claim is for denture, crown or bridge, is this an initial placement? (Provide pre-treatment x-rays for crown or bridge). ☐ Yes ☐ No

If no, give date of prior placement and reason for replacement.

I authorize release of any information or record requested in respect of this claim to Great-West Life or its agents. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's Signature _____ Date: _____

HAVE YOU COMPLETED ALL SECTIONS OF THIS CLAIM FORM?

CLEAR