the co-operators

Co-operators Life Insurance Company

DENTAL CLAIM FORM

PART 1 DENTIST

PATIENT

LAST NAME

GIVEN NAME

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

DENTIST:

PHONE NO:

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

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

DUPLICATE FORM ☐

DENTIST: INDICATE ALL MISSING TEETH

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

DATE OF SERVICE DAY	MO.	YR.	PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SUR-FACES	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

	DAY MONTH YEAR
EMPLOYMENT DATE	
EMPLOYEE'S/MEMBER'S EFFECTIVE DATE	
DEPENDENT'S EFFECTIVE DATE	
TERMINATION DATE (IF APPLICABLE)	
RETIREMENT DATE	

STATUS ☐ SINGLE ☐ COUPLE ☐ FAMILY

SIGNATURE OF AUTHORIZED OFFICIAL X

DATE (DAY MONTH YEAR)

PART 2 EMPLOYEE / MEMBER STATEMENT (Please Print)

Group No.	Account No.	PID#	Employers Name/Policyholder Name:

1. Employee's/Member's name _____ (first / initial / last) Previous surname (if applicable) _____

2. Employee's/Member's mailing address _____ (Street / City / Prov. / Postal Code)

3. Employee's/Member'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 your Plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account? ☐ Yes ☐ No

10. 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) _____

11. 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 18, 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 understand that Co-operators Life Insurance Company is committed to the protection of privacy and security of the personal information provided in connection with this claim and that the submission of false or incomplete information may cause delay or denial of this claim. The information I have provided is complete and accurate and I authorize any person or organization with information relevant to this claim to release that information as may be required for the investigation and administration of this claim. I confirm that I am authorized to act on behalf of the person for whom this claim is made. Any copy of this authorization shall be as valid as the original.

Employee/Member Signature _____ 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: DENTAL CLAIMS, THE CO-OPERATORS, 1920 COLLEGE AVE., REGINA, SASK., S4P 1C4 OR FOR ONLINE DENTAL (MANUAL CLAIMS SUBMISSION) GREEN SHIELD CANADA, P.O. BOX 1608, WINDSOR, ON N9A 7G1