THE Great-West Life ASSURANCE COMPANY ADMINISTRATORS FOR:

PUBLIC 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

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.
1. Have your Dentist complete Part 1.
2. Complete all questions in Part 2.
3. **SEND FORM TO:**

EMPLOYEES POSTED OUTSIDE CANADA:	Great-West Life Health & Dental Benefits Foreign Benefit Payments P.O. Box 6000 Winnipeg MB R3C 3A5
QUEBEC RESIDENTS OTHER THAN NATIONAL CAPITAL REGION	Montreal Benefit Payments Place Bonaventure Suite 5800 800 de la Gauchetière St. W Montreal QC H5A 1B9
OTHER CANADIAN RESIDENTS:	Winnipeg Benefit Payments P.O. Box 6025 Stn Main Winnipeg MB R3C 3C7

PART 2 EMPLOYEE (please print)

1. Employee's Full Name | Language Preference ☐ English ☐ French | Plan Number | Employee's Certificate Number C F

Employee's Address

2. Relationship of patient to employee | 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 existed for at least one year? ☐ Yes ☐ No

5. Are you or any of your dependants entitled to benefits as an 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 employee's birthday (day/month): _____/_____/ and
birthday of spouse or common-law partner (day/month): _____/_____/

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.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date: _____

HAVE YOU COMPLETED ALL SECTIONS OF THIS CLAIM FORM?

CLEAR