Government of Saskatchewan

THE Great-West Life ASSURANCE COMPANY

STANDARD DENTAL CLAIM FORM

Please print

Canadian Dental Association

Canadian Life and Health Insurance Association

Please see reverse for details on how to file your claim.

DENTIST STATEMENT

PATIENT

Last name | Given name

Address | Apt.

City | Prov. | Postal code

DENTIST

Unique no. | Spec. | Patient's office account no.

Phone no.

I hereby assign my benefits payable from this claim to the named dentist and authorize payments directly to him/her.

Signature of subscriber

For dentist 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

Date of service Day	Month	Year	Procedure code					Intl. tooth code		Tooth surfaces	Dentist's fee					Laboratory charge				Total charge					

This is an accurate statement of services performed and the total fee due and payable. E&OE

TOTAL FEE SUBMITTED

EMPLOYEE STATEMENT

Any treatment exceeding $500.00 must be approved by the Insurer before it begins.

Group Number | Employee ID Number | Division Number

Employee Surname | Given Name | Gender ☐ Male ☐ Female

Employee's Address (Street, City, Province, Postal Code) | Employee's Date of Birth Day | Month | Year

QUESTIONNAIRE

Patient's relationship to employee

☐ Self ☐ Spouse ☐ Child

Patient's Date of Birth Day | Month | Year

Spouse's Date of Birth Day | Month | Year

Does the claimant have any other Group Dental Coverage? ☐ Yes ☐ No

If Yes, indicate The Insurance Company

Is this dependent employed? ☐ Full-time ☐ Part-time

If child's age is over 21, indicate: ☐ Handicapped ☐ Student

If student, indicate the name of School or University | Student ID #

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

If yes, indicate date and details

Is this the initial placement for a denture, crown or bridge? ☐ Yes ☐ No

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

Is any treatment for orthodontic purpose? ☐ Yes ☐ No

Has payment been made by any other insurance or dental plan for services on this claim? ☐ Yes ☐ No

AUTHORIZATION

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 _____

CLEAR

M445D(PEBA)-3/06 Employer Statement is on the reverse side

THE Great-West Life ASSURANCE COMPANY

EMPLOYER STATEMENT

Employer Name _____ Group No. _____ Division No. _____

Has employee transferred from another division within the past 12 months? ☐ No ☐ Yes, from which division? _____

Date of Transfer: _____

Eligible Employee is ☐ (a) Permanent with 6 months service ☐ (b) Non-Permanent with 6 months service Hire Date _____

If (b), specify % reimbursement ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 100

Date (day, month, year) Employer authorized signature

HOW TO CLAIM DENTAL INSURANCE BENEFITS

As soon as you or an insured dependent incur covered dental expenses:

EMPLOYEE

1 Take this form to your dentist and have him/her complete the dentist's statement on the reverse side of this form.

2 Complete the employee statement and questionnaire. Please be sure you fully answer all questions.

3 Please sign and date the authorization section.

4 Under the co-ordination of benefits provision, if your spouse has coverage under another insurance plan, his/her charges must first be submitted under that plan. Charges for dependent children must first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year (excluding the year of birth).

EMPLOYER

1 Group Number, Division Number, Employee ID Number should be checked for accuracy. Incorrect information will only **delay payment** of the claim.

2 For **Employer Authorized Groups Only,** the Employer Statement must be complete as shown on the top of this page. Forms that do not have the signature of the official representative will be returned for completion.

REMINDER

This form must be completed in full. Incomplete forms will be returned to you, which will delay the processing of the claim.

DISCLOSURE

Great-West Life is committed to protecting the confidentiality of your personal information and will establish comprehensive safeguards to protect that confidentiality. Such safeguards include internal restrictions of access to your personal information by only individuals working for or on behalf of Great-West Life who have a need to know the information.

Any personal information you provide to us will be kept in a file established in our Group Life and Health Benefits Department and will only be used for the purpose outlined in your file and for which you have given your permission except where required by law, to protect the interest of Great-West Life or in the discharge of our public duty.

GREAT-WEST LIFE CLAIM OFFICE

Send completed form to the claim office below:

Regina Benefit Payments
P.O. Box 4408
Regina SK S4P 3W7
English: 1-866-289-5675 French: 1-866-814-6503

For the deaf or hard of hearing:
Toll Free: 1-800-990-6654
Or: (204) 946-7281

To access Claim Information on line please go to www.greatwestlife.com

- **Select Group Net for Plan Members**
- **Register (if this is the first time on the site)**
- **Sign in with your user name & password**