



DENTAL CLAIM FORM

PART 1 DENTIST / DENTURIST

NAME ADDRESS CITY, PROV. POSTAL CODE TELEPHONE	PATIENT'S LAST NAME (PLEASE PRINT)	GIVEN NAMES
	ADDRESS	APT.
	CITY	PROV.
	POSTAL CODE	TELEPHONE
	<input type="checkbox"/> Please check if address has changed in past 12 months.	

DATE OF SERVICE	INT. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S/DENTURIST'S FEE	TOTAL CHARGE	FOR DENTIST / DENTURIST USE ONLY FOR ADDITIONAL INFORMATION RE DIAGNOSIS PROCEDURES, OR COMPLICATIONS, AND SPECIAL CONSIDERATIONS.
DAY	MO.	YR.					
							I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE 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 OR ITS AGENTS.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED. E. & OE.

TOTAL FEE SUBMITTED →

SIGNATURE OF PATIENT (OR PATIENT / GUARDIAN)

I HEREBY ASSIGN BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED DENTIST/DENTURIST.

DENTIST / DENTURIST SIGNATURE _____ DATE _____ DAY _____ MONTH _____ YEAR _____ SIGNATURE OF INSURED MEMBER _____

PART 2 INSURED MEMBER

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S / DENTURIST'S OFFICE

INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS CLAIM

1. GROUP POLICY NUMBER 901504
 GROUP PLAN NAME I.B.E.W. Local Union 2085

2. NAME OF INSURED MEMBER _____
 ADDRESS OF INSURED MEMBER _____

MEMBER'S SOCIAL INSURANCE NUMBER - -

3. PATIENT NAME _____ DATE OF BIRTH _____
 GENDER _____ RELATIONSHIP TO MEMBER _____
 IF CHILD AGE 21 OR OVER INDICATE * STUDENT HANDICAPPED
 * Please provide proof of student attending Educational Institution

4. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES
 IF YES, GIVE DETAILS _____

B) IS CLAIM BEING MADE FOR WORKER'S COMPENSATION BENEFITS? NO YES

5. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLANS? YES NO
 IF YES INDICATE WHO IS INSURED UNDER THE OTHER PLAN. SELF SPOUSE
 IF SPOUSE, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH / /
 EFFECTIVE DATE OF COVERAGE / /
 NAME OF INSURER _____ POLICY NO. _____

* NOTE: For coordination of benefits, dependent children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.

6. IF DENTURE, BRIDGE OR CROWN IS THIS INITIAL PLACEMENT?
 UPPER YES NO
 LOWER YES NO
 IF YES, GIVE DATE OF EXTRACTION(S). _____
 IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.
 DATE _____

PART 3 HEALTHCARE SPENDING ACCOUNT

Any amount not eligible for reimbursement from the contents of this claim (e.g. deductible and co-insurance payment, claim that has exceeded an allowable maximum, health and dental expenses not covered under the group insurance plan, etc.) is to be automatically applied to the extent of the balance in my Healthcare Spending Account, if any. YES NO

EMPLOYEE AUTHORIZATION AND DECLARATION

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. I authorize Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

Date / / Plan Member's Signature _____