THE Great-West Life ASSURANCE COMPANY

saho Saskatchewan Association of Health Organizations

STANDARD DENTAL CLAIM FORM

Please print

Canadian Dental Association

Canadian Life and Health Insurance Association

PART 1 DENTIST

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

PATIENT

Last name | First 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 ☐

Office verification / Dentist's signature

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

Was pre-authorization obtained for these procedures?

☐ Yes ☐ No

Is any treatment for orthodontic purposes?

☐ Yes ☐ No

If yes, attach a copy of the treatment plan.

PART 2 EMPLOYEE STATEMENT

It is suggested that any treatment exceeding $500.00 should be approved by the Insurer before it begins

Group Contract number **335663** | Certificate Number | Employer

Employee Last Name | First Name | Gender ☐ Female ☐ Male

Employee's Address (Street, City, Province, Postal Code)

PART 3 CO-ORDINATION OF BENEFITS

1. Patient's relationship to you _____
2. Patient's Date of Birth: ____ /____ /____ (Day Month Year)
3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
4. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____
   d) Is he/she mentally or physically challenged ☐ Yes ☐ No
5. a) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   b) Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy number _____
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____ /____ /____ (Day Month Year)
6. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location, and explain how accident happened:
7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement

PLEASE SIGN THE AUTHORIZATION SECTION

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 _____

M445D(335663)-4/07

CLEAR

THE Great-West Life ASSURANCE COMPANY

HOW TO CLAIM DENTAL INSURANCE BENEFITS

Electronic Dental Claim Submission / EDI:

Many Dental offices can accommodate Electronic Dental Claim Submission. Your Dental office will require you to provide your Group Contract Number and Certificate Number to complete the electronic transaction.

Ask your Dental office for more details.

Paper Claim Submission:

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 should first be submitted to the plan of the parent whose month and day of birth comes earlier in the calendar year.

5 Mail the completed form directly to the claims office indicated below.

REMINDER

Proof of claim must be submitted within 120 days following the earlier of your termination of employment or the end of the calendar year in which the expense is incurred. Claims submitted after the deadline will not be considered for payment.

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

MAIL THE COMPLETED FORM DIRECTLY TO THE CLAIMS OFFICE INDICATED BELOW

Regina Benefit Payments
P.O. Box 4408
Regina SK S4P 3W7
Toll Free: 1-866-408-0213

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