







## **Dentalcare Expenses Statement**

## **INSTRUCTIONS**

- 1. Complete page 1 and 2 of this form in full.
- 2. Sign and date the form.
- 3. Please retain copies for your files as original receipts will not be returned.
- 4. If you wish benefits to be paid directly to the dentist, sign the assignment portion of PART 1 below. Assignment of benefits is irrevocable. Canada Life may discuss details of this claim with the assignee.
- Send to the appropriate Benefit Payment Office for your plan. See PART 7.

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 their behalf when necessary to confirm eligibility and to mutually manage the claims.

PATIENT Last name Give		iven name		Unique No.	Spec.	Patient's office account No.	benefits payable from t	
act name	anie Given name			DENTIST			claim to the named den and authorize payment	
Address Apt./Suite No.				directly to the dentist.				
City Prov. Postal code			Phone No.			Signature of subscribe		
or dentist's use only, formation, diagnosis		I understand that that I am finance				covered by or may exceed my	plan benefits. I underst	
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ay Month Year	Code	Code	Sui	rfaces	Fees	Charge	Charges	
nis is an accurate s	statement of services	s performed and t	the total fe	e due and pa	able, e. & o.e.	TOTAL FEE SUBMITTE	D  \$	
	Details - To be	completed by	/ Dentis	t				
Please specify claim details.	1. Is this treatment required as the resolution of an accident?			sult No	3 If claim is placemen	s for a denture, crown, ont?	r bridge, is this init	
	If yes, please			110	•	e date of prior placemen	t and reason for	
	Date:	Date: Location:			replacem		t and reason for	
	Explain how accident happened							
						s for a denture or bridge,	, please provide	
	2. Is a claim bei	ng made for Wo	rkers' Cor	mpensation				
	Benefits?	🔲 Yes 🔲 No	)					

## Canada Life Dentalcare Expenses Statement

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