canada life™

Newfoundland Labrador

CANADIAN DENTAL ASSOCIATION

CLHIA ACCAP

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.
5. 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.

PART 1 - DENTIST INFORMATION - To be completed by Dentist (1)

PATIENT

Last name | Given name

Address | Apt./Suite No.

City | Prov. | Postal code

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

DENTIST

Phone No.

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to the dentist.

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. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of patient (parent/guardian)

Office verification

Date of Service Day Month Year	Procedure Code	Intl. tooth Code	Tooth Surfaces	Dentist Fees	Laboratory Charge	Total Charges
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00
						$ 0.00

This is an accurate statement of services performed and the total fee due and payable, e. & o.e. **TOTAL FEE SUBMITTED** $ 0.00

PART 2 - Claim Details - To be completed by Dentist (2)

Please specify claim details.

1. Is this treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, please provide:
   Date: | Location:
   Explain how accident happened
2. Is a claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No
3. If claim is for a denture, crown, or bridge, is this initial placement? ☐ Yes ☐ No
   If no, give date of prior placement and reason for replacement:
4. If claim is for a denture or bridge, please provide missing tooth number(s):

M445D(168074)-6/20

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PART 3 - Plan Member Information 3

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name
GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Plan number
168074

Plan member I.D. number

Plan Member Name

Last name

First name

Plan Member Address

Number and street

City or town

Province

Postal code

Date of birth: Day | Month | Year

Language preference:
☐ English ☐ French

PART 4 - Coordination of benefits 4

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No If yes, please provide:

Name of insurance company

Plan number

Plan member I.D. number

If spouse's plan, please provide spouse's date of birth:
Day | Month | Year

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

PART 5 - Patient information 5

Complete this section if claim is for spouse or dependant.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 21 years: Full time student hours per week	Full time student Yes	Full time student No	If employed, how many hours worked per week?	Does Patient Reside with Plan Member? Yes	Does Patient Reside with Plan Member? No
				☐	☐		☐	☐

PART 6 - Confirmation, Authorization and Signature 6

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Canada 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 Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member signature X_____ Date: Day | Month | Year

PART 7 - Submitting Your Claim 7

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Questions? Call Toll Free: 1.844.349.5656

Newfoundland and Labrador Benefit Payments
PO Box 13820 Station A
St John's NL A1B 0S4

Questions? Call Toll Free: 1.844.349.5656

Newfoundland and Labrador Benefit Payments
PO Box 729 Station Main
Corner Brook NL A2H 6G7

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us: TTY to Voice: 711 Voice to TTY: 1-800-855-0511

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