The Equitable Life Insurance Company of Canada
One Westmount Road North, P.O. Box 1603, Stn Waterloo, Waterloo, Ontario N2J 4C7
General Inquiries (519) 886-5110 1-800-265-8878 • Fax: (519) 883-7403
Website: www.equitable.ca • E-mail: head-office@equitable.ca

DENTAL CLAIM FORM

PART 1 - DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

PATIENT

LAST NAME GIVEN NAMES

ADDRESS APT.

CITY PROVINCE

POSTAL CODE

DENTIST

NAME

ADDRESS

POSTAL CODE

TELEPHONE NO.

SIGNATURE OF SUBSCRIBER (INSURED)

FOR DENTIST USE ONLY — FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED 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

DUPLICATE FORM ❑

DATE OF SERVICE Day	Mo.	Yr.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E. & OE.

TOTAL FEE SUBMITTED $

Falsifying or tampering with claim documents / receipts could have legal consequences.

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE YOUR DENTIST COMPLETE PART 1, 2 AND 3.
2. AFTER PART 1 IS COMPLETE, SIGN PART 1 ACKNOWLEDGING DENTIST'S FEE.
3. ENSURE COMPLETION OF PART 2 AND 3 IN FULL. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR CLAIM.

PART 2 - EMPLOYER/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO: _____ DIVISION NO: _____

EMPLOYER: _____

2. INSURED'S NAME (PLEASE PRINT): _____

DATE OF BIRTH: (Day_____Month_____Year _____) INSURED'S CERTIFICATE/I.D. NO: _____

Please complete reverse side →

520(2004/06/15)

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DENTAL CLAIM FORM

PART 3 - PATIENT INFORMATION

1. **PATIENT**: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER - _____ DATE OF BIRTH: (Day_____Month_____Year _____)

   IF CHILD, INDICATE: ❑ STUDENT ❑ HANDICAPPED

   IS HE/SHE ATTENDING SCHOOL FULL TIME? ❑ NO ❑ YES → IF YES, INDICATE SCHOOL: _____

   WHEN WILL HIS/HER SCHOOLING BE COMPLETED? (Day_____Month_____Year _____)

   IS HE/SHE EMPLOYED FULL TIME? ❑ NO ❑ YES IS HE/SHE EMPLOYED PART TIME? ❑ NO ❑ YES → HOW MANY PART TIME HOURS PER WEEK? _____

2. ARE DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN OR CONTRACT? ❑ NO ❑ YES → IF YES, INDICATE THE FOLLOWING:

   NAME OF OTHER INSURING AGENCY OR PLAN:_____ POLICY NO: _____

   IF THIS PLAN IS ALSO WITH EQUITABLE LIFE®, PLEASE INDICATE MEMBER'S I.D.: _____

   DO YOU WANT US TO CO-ORDINATE BENEFITS (PROCESS BOTH CLAIMS)? ❑ NO ❑ YES → IF YES,

   SPOUSE'S SIGNATURE: _____ DATE: (Day_____Month_____Year _____)

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ❑ NO ❑ YES → IF YES, GIVE DATE AND DETAILS SEPARATELY.

   A) ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ❑ NO ❑ YES
   (ie. School Insurance, Workers' Compensation, etc.)

4. IS THIS CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? ❑ NO ❑ YES

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ❑ NO ❑ YES → IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.

6. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ❑ NO ❑ YES

7. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER/PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
   THE CLAIM INFORMATION WILLINGLY PROVIDED BY ME TO EQUITABLE LIFE HELD IN THEIR FILE, WILL BE USED BY EQUITABLE LIFE FOR THE PURPOSES OF CLAIMS PROCESSING AND ADJUDICATION. I UNDERSTAND AND AUTHORIZE THAT FOR THE ABOVE PURPOSES THE PERSONAL INFORMATION ON FILE IS ACCESSIBLE TO, AND MAY BE EXCHANGED WITH, AUTHORIZED EMPLOYEES OF, AND RELEVANT THIRD PARTIES RETAINED BY EQUITABLE LIFE, ITS SALES DISTRIBUTION NETWORK, PARTICIPATING REINSURER(S), OTHER INSURANCE COMPANIES, INVESTIGATIVE ORGANIZATIONS, HEALTH CARE PROVIDERS, INCLUDING, BUT NOT LIMITED TO, PHARMACIES, PHYSICIANS, DENTISTS, AND ANY OTHER PERSON OR PARTY WHOM I AUTHORIZE.
   IF APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION ALSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES. I UNDERSTAND THAT CLAIMS MADE UNDER THE GROUP INSURANCE POLICY ARE SUBMITTED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE EQUITABLE LIFE TO EXCHANGE INFORMATION ABOUT THESE CLAIMS WITH ME OR ANY PERSON ACTING ON MY BEHALF, INCLUDING A SPOUSE OR DEPENDENT, AS DEEMED NECESSARY FOR THE PURPOSE OF CONFIRMING ELIGIBILITY AND ASSESSING AND MANAGING THE CLAIM.

_____ DATE: (Day_____Month_____Year _____)
SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

Falsifying or tampering with claim documents / receipts could have legal consequences.

Please complete reverse side →

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