



Approved by the Canadian Dental Association

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|---------------------------------|--|---|---|
| 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. |
| P A T I E N T | LAST NAME _____ GIVEN NAME _____ ADDRESS _____ APT. _____ CITY _____ PROV. _____ POSTAL CODE _____ | D E N T I S T PHONE NO. _____ | |

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

DUPLICATE FORM

| DATE OF SERVICE | | | PROCEDURE CODE | INT'L TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES | FOR CARRIER USE |
|-----------------|-----|-----|----------------|------------------|----------------|---------------|-------------------|---------------|-----------------|
| DAY | MO. | YR. | | | | | | | |
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Please mail to:

The Empire Life Insurance Company
 Group Health Claims
 473 Counter St., Suite 400
 Kingston, ON K7M 8Z6

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

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. A separate form is required for each person for whom a claim is being made.
2. Have Part 1 Dentist Statement completed and returned to you.
3. Fully complete all questions in Part 2 for Subscriber and Dependants.
4. Return form to your Plan Administrator when completed. Additional forms are available from your Personnel Office/Plan Administrator.

We strongly recommend that if charges will be \$300.00 or more your claim be submitted for predetermination of benefits before the work is started. The submission of xrays will be required for crowns or bridge work. These will be returned promptly to your dentist.

PART 2 INSURED/SUBSCRIBER

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

Patient: relationship to Subscriber _____ Date of Birth _____

Is he/she employed? No Yes - Where? _____ # Hrs. Worked _____

Is he/she wholly dependent on you for support? No Yes

If child age 21 or over, indicate if Student: Full time Part time if Handicapped

If student, indicate school _____

Are any dental benefits or services provided under any other Group Insurance or Dental Plan? No Yes Policy No. _____

Name of Insuring Agency _____

If yes, provide spouse's Date of Birth _____ and Subscriber's Date of Birth _____

If denture, crown or bridge, is this initial placement? No Yes

Give date of prior placement and reason for replacement _____

Is any treatment for orthodontic purposes? No Yes

Is any treatment required as the result of an accident? No Yes

Give date and details _____

I authorize:

1. the release of any information or records requested in respect of this claim to The Empire Life Insurance Company, its authorized representatives or its consultants and certify that the information given is true, correct and complete to the best of my knowledge, and
2. The Empire Life Insurance Company to release any statistical information regarding claims paid on behalf of me and my eligible dependants, other than specific details relating to a medical condition, to my employer.

A photocopy of this authorization should be as valid as the original.

Date _____ Subscriber's Signature _____

Day Month Year

PART 3 POLICY OWNER/EMPLOYER

Group Policy No. _____ Division No. _____ Employer _____

Cert. No. _____ Name of Subscriber _____

Date Insured _____ Date Dependant Insured _____ Date terminated _____

Is claim being made for Workers' Compensation Benefits? No Yes

Authorized signature _____ Telephone No. _____ Date _____

Day Month Year