INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 793 LIFE & HEALTH BENEFIT PLAN

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

PART 1 DENTIST

CLAIM FOR DENTAL BENEFITS

DENTIST

NAME

ADDRESS

CITY, PROV.

POSTAL CODE

TELEPHONE

UNIQUE IDENTIFYING NUMBER

PATIENT'S LAST NAME | GIVEN NAMES

ADDRESS | APT.

CITY | PROV.

POSTAL CODE

DATE OF SERVICE DAY	MO.	YR.	INTL. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE(S)	DENTIST'S FEE	TOTAL CHARGE(S)

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED, E. & O.E.

TOTAL SUBMITTED FEE

DENTIST'S SIGNATURE | DATE | DAY | MONTH | YEAR

FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURES, OR COMPLICATIONS AND SPECIAL CONSIDERATIONS.

I UNDERSTAND THAT FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY THE ABOVE NOTED BENEFIT PLAN OR MAY EXCEED MY ENTITLEMENT THERE-UNDER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION PERTINENT TO THIS CLAIM TO THE ABOVE NOTED BENEFIT PLAN OR ITS AUTHORIZED REPRESENTATIVE FOR THE PURPOSE OF SETTLING THIS CLAIM.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

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

SIGNATURE OF MEMBER

FOR PLAN ADMINISTRATORS USE ONLY

AMOUNT PAYABLE $	¢	

INSTRUCTIONS

If charges will be $300 or more, your claim should be submitted for Predetermination of Benefits.

Routine oral examinations, scaling and cleaning, fluoride treatment, x-rays, basic restorations and emergency treatment may be performed by your dentist prior to submitting your claim for Predetermination of Benefits.

X-rays may be required to be submitted for crowns or bridge-work.

X-rays will be returned promptly to your dentist.

Mail Claim Forms to:

Global Benefits
Plan Administrator of I.U.O.E. Local 793
88 St. Regis Crescent South, Toronto, ON M3J 1Y8
Tel: (416) 635-6000 Fax: (416) 635-6464
Toll Free: 1-800-663-4500

PART 2 — MEMBER'S STATEMENT

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

1. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH ____/____/____ (DAY MONTH YEAR)
   IF CHILD AGE 21 OR OVER INDICATE ☐ STUDENT ☐ HANDICAPPED

2. AT THE TIME OF TREATMENT WAS THE PATIENT A FULL TIME STUDENT? ☐ YES ☐ NO
   A. IF "YES" COMPLETE THE FOLLOWING:
   NAME OF ACCREDITED SCHOOL: _____
   B. IF "NO" COMPLETE THE FOLLOWING:
   PLACE OF EMPLOYMENT: _____
   STARTING DATE OF EMPLOYMENT: FULL TIME _____
   PART TIME _____
   IF THIS PATIENT WAS NEITHER A FULL TIME STUDENT NOR EMPLOYED, WAS HE/SHE RECEIVING UNEMPLOYMENT INSURANCE? ☐ YES ☐ NO
   WILL THIS PATIENT BE CLAIMED AS A DEPANDENT ON YOUR FEDERAL INCOME TAX FOR THE YEAR IN WHICH SERVICES WERE RENDERED? ☐ YES ☐ NO

3. ARE ANY DENTAL BENEFITS FOR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOVT, AGENCY OR DENTAL PLAN? ☐ YES ☐ NO

4. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? GIVE DATE AND DETAILS ☐ YES ☐ NO

5. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO

6. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT?: GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ☐ YES ☐ NO

7. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY OR OTHERWISE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

8. INITIAL CLAIM? ☐ SUBSEQUENT? ☐

9. MEMBERS S.I.N. ☐☐☐ - ☐☐☐ - ☐☐☐

10. MEMBERS DATE OF BIRTH ____/____/____ (DAY MONTH YEAR)

11. I AUTHORIZE RELEASE OF THE INFORMATION PERTINENT TO THIS CLAIM TO THE ABOVE NOTED BENEFIT PLAN OR ITS AUTHORIZED REPRESENTATIVE FOR THE PURPOSE OF SETTLING THIS CLAIM.

MEMBER'S NAME: _____ (PLEASE PRINT)

ADDRESS: _____

TELEPHONE NUMBER: _____

DATE: ____/____/____ (DAY MONTH YEAR)

MEMBERS SIGNATURE: _____

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ____/____/____ Signature of Member _____ Telephone Number ( ) _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL