

# Dental Claim Form



Approved by the Canadian Dental Association



## 1 To be completed by Dentist

P A T  I E  N T  T	Last Name <u>Anderson</u>	Given Name <u>David</u>	Unique Number <u>123371</u>	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.  <u>Anderson AND</u> Signature of Subscriber			
Address <u>102, church street Apt. R6</u>		D E N T I S T	Phone No.: <u>515-843-5016</u>						
City <u>Kitchener</u>		Prov. <u>ON</u>	Postal Code <u>N5N 1Z6</u>	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 \$ <u>120</u> is accurate and has been charged to me for services rendered. I authorize release of the information 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.					
For Dentist's Use Only – For additional information, diagnosis, procedures, or special consideration.				Signature of Patient (Parent/Guardian) <u>Ann Fran.</u>					
Duplicate Form <input type="checkbox"/>				Office Verification/Dentist's Signature <u>R. Dr. Amrit</u>					
Date of Service Day Month Year		Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges	For Plan Administrator Use Only	
29	11	2024	02301		\$30				
29	11	2024	02304		\$90		\$120		
This is an accurate statement of services performed and the total fee due and payable, E & OE				TOTAL FEE SUBMITTED		\$120			

## 2 Information about you – be sure to fully complete this section

Contract number <u>160101</u>	Member ID number <u>TS22000001A</u>	Your plan sponsor/employer <u>CDSP</u>		Preferred language of correspondence <input checked="" type="checkbox"/> English <input type="checkbox"/> French
Your last name <u>Lalam</u>	First name <u>Noah</u>		Date of birth (yyyy-mm-dd) <u>1983-02-02</u>	Daytime phone number <u>515 843 5016</u>
Your address (street number and name) <u>102, church St, Kitchener</u>	Apartment or suite <u>R6</u>	City <u>KITCHENER</u>	Province	Postal code <u>N5N 1Z6</u>

## 3 Spouse and children covered by this claim – complete this section if claim is for spouse or child

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	
Child's name	Relationship to you	Date of birth (yyyy-mm-dd)	Complete for overage dependents (refer to benefit information for age limits) <input type="checkbox"/> Disabled <input type="checkbox"/> Full-time student

## 4 Co-ordination of benefits – complete this section if your spouse and/or children has coverage under any other dental plan or contract

Is your spouse or are your children covered for any of these expenses under any other dental plan or contract?  No  Yes

- If yes:
- You must submit a claim for your spouse to his/her plan first.
  - You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year.

If your spouse's plan is also with us, complete the following:

Contract number	Member ID number	Spouse's date of birth (yyyy-mm-dd)	Do you want us to co-ordinate benefits (process both claims)? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, spouse's signature <u>X</u>			Date (yyyy-mm-dd)

## 5 | Details of claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

1. Are any expenses the result of an accident?  No  Yes If yes, complete the following:

When did the accident occur? (yyyy-mm-dd)	Where did the accident occur? <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	How did the accident occur?
Are any expenses the result of a condition covered by a workers' compensation program? <input type="checkbox"/> No <input type="checkbox"/> Yes		

2. Is this treatment for orthodontic purposes?  No  Yes Implants?  No  Yes

3. Crowns, Bridges, Dentures Is this the initial placement?  No  Yes

If No, date of prior placement (yyyy-mm-dd)	Reason for replacement	If Yes, date teeth were extracted (for denture or bridge) (yyyy-mm-dd)
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Please include the following to facilitate handling of your claim:

- Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays)
- List of all missing teeth (for bridges only)

## 6 | Authorization and Signature – you must complete this section

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada ("Sun Life") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

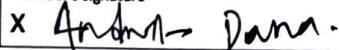
In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

Member's signature

X 

Date (yyyy-mm-dd)

2024-12-04

## 7 | Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at [www.sunlife.ca/privacy](http://www.sunlife.ca/privacy) or call us for a copy.

Questions? Please visit [www.sunlife.ca](http://www.sunlife.ca) or call our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

## Mailing instructions – keep a copy of your claim form and receipts for your records

Mail your completed form to the claims office nearest you.

Sun Life Assurance Company  
of Canada  
PO Box 11658 Stn CV  
Montreal QC H3C 6C1

Sun Life Assurance Company  
of Canada  
PO Box 2010 Stn Waterloo  
Waterloo ON N2J 0A6