

Sun Life 2/14/24 10:15 AM 000456 3 TR120172614

#873589
PROTECTED
Health Insurance Claims
Sun Life Assurance
Company of Canada
P.O. Box 6199 STN CV
Montreal QC H3C 3A8

February 14, 2024
Dr. Emily Johnson
5108 DEF Medical Blvd
P.O. Box 64890
Vancouver BC V5K 1B2

Dear Dr. Johnson,
Re: Contract No.: 91764
Sub No.: 321
Certificate/ID No.: 123456789

Member's Name: Jane Doe
Claimant Name: John Doe
Control No.: 654321

We refer to the claim for dental treatment expenses sent to us by your patient, John Doe.

To determine the amount eligible for benefits within the terms of his contract, our Dental Review Committee requires, in writing, the following additional information:

1. Pre-treatment x-rays, photos and/or study models - the type of evidence which clearly shows the condition of teeth numbers 12, 13.
 - PA 12, 13, 15/03/24 Non restorable + root fracture.
 - PA 13, 01/10/23 (crown) + 15/12/23 - fractured root structure.

NOTE: When submitting the x-rays, be sure to place them inside a sealed envelope labeled with patient's name and dentist's name and address and then attach to this form. If submitting duplicate x-rays, please be sure to label them appropriately RIGHT and LEFT.

2. A list of all missing teeth in the entire dentition as well as a description of migration if it has occurred.
 - 11, 21 (planned for implant + crown), 14 (planned for implant + crown) 16, 26.
3. Was there a previous appliance replacing any of the missing teeth?

- YES

If so, for any missing teeth, please specify the type of prosthesis:

- Fixed: Implant supported FPD 12 to 14 (3 pontic)
- Removable: No
- Other: No

SCANNED

Dental Claim Form

Approved by the Canadian Dental Association

Sun Life**1 To be completed by Dentist**

PATIENT				
Last Name: Doe	Given Name: Jhon	Unique Number:78100	Spec.: DDS	
Patient's Office Account No.:51320	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.			
Address: 6580 DEF Medical Blvd	Apt.:3A	City: Vancouver	Prov.: BC	Postal Code:
			Phone No.: 604-555-2789	

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 \$750 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.

Signature of Patient (Parent/Guardian): Jhon Doe

Signature of Subscriber: Jhon Doe

Office Verification/Dentist's Signature: Dr. Emily Johnson

Date of Service:			Procedure Code	Int. Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges
Day	Month	Year						
14	02	2024	11112	12,13	MB	\$300	\$75	\$375
14	02	2024	41211	13	MB	\$300	\$75	\$375

This is an accurate statement of services performed and the total fee due and payable, E & OE.

TOTAL FEE SUBMITTED: \$750

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

Contract number: 897614	Member ID number: TY22000014	Your plan sponsor/employer: ABC Corp	Preferred language of correspondence: <input checked="" type="checkbox"/> English <input type="checkbox"/> French
Your last name: Doe	First name: Jhon	Date of birth (yyyy-mm- dd): 1984-07-03	Daytime phone number: 510 858 3090
Your address (street number and name): 414 SCENIC AV Site	Apartment or suite:	City: LETHBRIDGE	Province: AB Postal code:T1J3E5

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

Spouse's last name: Doe	First name: Jane	Date of birth : 1988-04-22
Child's name: Alex Doe	Relationship to you: Son	Date of birth : 2012-08-10
		Complete for coverage dependents (refer to benefit information for age limit)
		<input type="checkbox"/> Disabled <input checked="" 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 checked="" type="checkbox"/> Yes
If yes, spouse's signature: X	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?

5 Details of Claim

☒ No ☐ Yes If yes, complete the following:

- When did the accident occur? (yyyy-mm-dd):
- Where did the accident occur? ☐ Work ☐ Home ☐ Other
- How did the accident occur?

Are any expenses the result of a condition covered by a workers' compensation program?

☒ No ☐ 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):

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 of any evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and share that information about me, my spouse and/or dependents concerning this claim may be used and disclosed to any 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.

6 Authorization and Signature – you must complete this section

Member's signature: 

Date: 2024-08-08

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 or call us for a copy.

Questions? Please visit www.sunlife.ca or call our toll-free number 1-810-331-6312 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
P.O. Box 11658 Stn CV
Montreal QC H3C 5C1

Sun Life Assurance Company of Canada
P.O. Box 2010 Stn Waterloox
Waterloo ON N2J 0A6

DRUG MART



103 BIG LAND ST.
ANYTOWN, ON L4V 3K3 (915) 505-1619

(Test 2.14 1/1)

Rx: 438769031

John Doe
850 Lasalle
Georgetown, NFLD, A4H 3V7
Rx: ZOFRAN 4MG TABLET
Pharmacist: 1

Refill:5

LIC: #1

\$:50.00

F: 30.00

C: 20.00

Patient Pays: \$50.00
