Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. 066290500 | SPEC. | PATIENT'S OFFICE ACCOUNT NO: 07095

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her

SIGNATURE OF SUBSCRIBER

PATIENT: WANG, Mr. Jun Sheng

DENTIST: Dr. Vicken Takvorian
62E Stonehaven Drive
Kanata, Ontario
K2M 2Y2
Fax (613)270-8762
PHONE NO. (613)270-0006

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 $ 150.00 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)

Duplicate Form [X]

Office Verification VICKEN TAKVORIAN D.M.D.

Date of Service Day Mo. Yr.	Pro-cedure Code	Intl. Tooth Code	Tooth Sur-faces	Dentist's Fee	Laboratory Charge	Total Charges
26/OCT/12	01205			125.00		125.00
26/OCT/12	02111			25.00		25.00

For Carrier Use

Allowed Amount	Inc	%	Patient's Share

Cheque No.	Date

Deductible	Patient Pays	Plan Pays

Claim No.

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

TOTAL FEE SUBMITTED 150.00

INSTRUCTIONS FOR CLAIM SUBMISSION

Being a standard form, this cannot include specific instructions on where it should be sent, depending on who is the carrier for your plan.
You can obtain details from either your plan booklet, your certificate or from your employer.
If your plan requires submission directly to the carrier, please send this form with only parts 1, 2, and 3 completed to the carrier's appropriate claims office.
*If your plan requires submission directly to your employer, please direct this form to your personnel office/plan administrator who will complete part 4 and forward the form to the carrier.

PART 2 — EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. Group Policy/Plan No.

Division Section No.

2. Your Name (Please Print)

Employer

Your Cert. No. or S.I.N. or ID. No.

Name of Insuring Agency or Plan

Your Date of Birth Day Month Year

PART 3 — PATIENT INFORMATION

1. Patient: Relationship to employee/ Plan member/Subscriber
Date of Birth Day/Mth/Year
If child indicate Student [ ] Handicapped [ ]
If student, indicate school
Patient ID. No.

2. Are any dental benefits or services provided under any other Group Insurance or Dental plan, W.C.B. or Gov't Plan? No [X] Yes [ ]

Policy No. Spouse Date of Birth

Name of other Insuring Agency or Plan

3. Is any treatment required as the result of an accident? If yes, give date and details separately. No [X] Yes [ ]

4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement No [ ] Yes [ ]

5. Is any treatment required for orthodontic purposes? No [X] Yes [ ]

6. 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.

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER DATE 27/OCT/12 Day Month Year

PART 4 — POLICY HOLDER/EMPLOYER (for completion only if applicable. SEE ABOVE*)

	DAY	MONTH	YEAR
1. Date coverage commenced			
2. Date dependent covered			
3. Date terminated			

4. Contract holder

DATE (DAY MONTH YEAR)

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

All information recorded on this form is confidential

BRIDLEWOOD DRUG MART Proxim
6584403 CANADA LIMITED
64 STONEHAVEN DR., KANATA, ON K2M 2Y2 613-254-9918

OFFICIAL PRESCRIPTION RECEIPT

Rx: 9029014 MS
Wang, Junsheng Fri 26-Oct-2012
6 O'Shaughnessy
Kanata, ON (613) 618-1057
20 TAB **Ratio-Lenoltec No 3 30mg**
Acetaminophen/Caffeine/Codeine Phos 30mg NEW RX
DIN: 00653276 TEV Refills: 0
Dr. Takvorian, Vicken Doc# 02:D62905
Cost: 1.44
Fee: 10.99
Total: 12.43

Patient Pays: 12.43

Pharmacist's Signature

BRIDLEWOOD
DRUG MART
64 STONEHAVEN DR.
KANATA, ON. K2M 2Y2
PH: 613-254-9918

10/26/2012 000000
#0551 1:41PM SERV.01 0001

RX $12.43
RX $14.11

***TOTAL $26.54
CASH $40.00
CHANGE $13.46

BRIDLEWOOD DRUG MART Proxim
6584403 CANADA LIMITED
64 STONEHAVEN DR., KANATA, ON K2M 2Y2 613-254-9918

OFFICIAL PRESCRIPTION RECEIPT

Rx: 1214705 MS
Wang, Junsheng Fri 26-Oct-2012
6 O'Shaughnessy
Kanata, ON (613) 618-1057
40 TAB **Apo-Pen VK 300mg**
Penicillin V Potassium 300mg NEW RX
DIN: 00642215 APX Refills: 0
Dr. Takvorian, Vicken Doc# 02:D62905
Cost: 3.12
Fee: 10.99
Total: 14.11

Patient Pays: 14.11

Pharmacist's Signature

GlobalExcel®

VISITORS TO CANADA TRAVEL INSURANCE
CLAIM FORM

Please send your claim to:
Global Excel Management Inc., 73 Queen, Sherbrooke, Qc J1M 0C9

Contract/Policy No.: 00000 1790 420

Claim No.: _____

IMPORTANT: You must complete all sections of the form so the evaluation of the claim can proceed without delay. It may be returned to you if the information is incomplete or incorrect.

SECTION A PATIENT INFORMATION

Last Name: WANG	First Name: JUNSHENG	Date of Birth: 05 / 10 / 39	
Address in Canada: 6 SHAUGHNESSY CRESCENT			Apt.
City: OTTAWA	Province: ONTARIO	Postal Code: K2K 2P1	
Telephone: (613) 271-2688	E-mail: andyjin@yahoo.com		
Family doctor in the country of origin	Name		
	Address		Telephone ( )
Contact person name in Canada: WANG, WEIJIANG			Telephone: (613) 668-2370
Address: 6 SHAUGHNESSY CRESCENT, OTTAWA, ONTARIO			
Reason for consultation or diagnostic: TOOTH PAIN			
Is this reimbursement request the result of an accident? ☐ Yes ☒ No			
Accident type: ☐ Work ☐ Car ☐ Other other If other, what type:			
If this is for a work related accident: No			
Employer			Telephone ( )
Contact Person Name			
If this is for a car related accident No			
Insurance Company Name of the car(s) involved			Telephone ( )
Policy and/or file #: 00000 1790 420			

SECTION B INFORMATION RELATING TO YOUR VISIT TO CANADA

Your Passport No.: G5134 3037	Visa No.: CC175 974 735	Visa-type and length: V-1
Country of residence/origin: P.R. CHINA	Date of arrival to Canada: 03 / 11 / 12	Scheduled return date: 12 / 31 / 13
Airline: AIR CANADA	Airline ticket no.: 014-5520 687754	Point of entry into Canada: TORONTO

SECTION C OTHER INSURANCE

❶ Are you covered by U.S. Medicare? ☐ YES ☒ NO

❷ Do you have group (employee/retiree) benefits? ☐ YES ☒ NO

If YES, please continue, otherwise proceed to question 3.

Your Group Benefits are provided by (check all that apply): ☐ Your employer ☐ Your spouse's employer ☐ A retiree plan

Name of employee/retiree: _____ Name of employer/group: _____

Group no.: _____ ID no. and/or Cert no.: _____

Name of insurance company: _____

Does the policy have a lifetime maximum? ☐ YES ☐ NO If YES, indicate lifetime maximum $ _____

50 36 CLM ECA 1208 VTC

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM ➘

SECTION C — OTHER INSURANCE (continued)

❸ Do you have benefits provided by (check all that apply): No ☐ Health insurance ☐ Home insurance ☐ Auto insurance ☐ Other

Name of insurance company: Policy/ID no.:

❹ Do you have a credit card coverage? No ☐ YES ☐ NO

If YES: Card no. Bank Name:

AS INDICATED IN YOUR POLICY, YOUR TRAVEL INSURANCE PLAN PROVIDES COVERAGE IN EXCESS OF ANY OTHER APPLICABLE INSURANCE (INDIVIDUAL, GROUP OR GOVERNMENT). FOR GLOBAL EXCEL MANAGEMENT INC., TO SEEK REIMBURSEMENT FROM THESE SOURCES YOU MUST COMPLETE THE FOLLOWING SECTION D.

SECTION D — AUTHORIZATION AND RELEASE

1. I assign to Global Excel Management Inc. any indemnity obtainable from other sources for covered losses under this policy. I also direct these sources to forward payment to Global Excel Management, Inc. for my claims submitted by Global Excel Management Inc. with regard to these losses and to exchange information that facilitates this process.
2. I authorize any hospital, physician, or medical facility to send my medical information to Global Excel Management Inc., authorized representatives of the Insurer. I further consent to the disclosure of this information by Global Excel Management Inc. to other sources as may be required to obtain benefits from other sources.
3. I warrant that neither I nor any insured person have any additional coverage through any other insurer (other than that listed above).
4. I understand that my insurance shall be void if, whether before or after the loss, any person has concealed or misrepresented any fact or circumstance concerning this claim.

Patient's or Authorized Person's Signature Junsheng wang **Date** 2012-11-3

SECTION E — REIMBURSEMENT

If the bills have been paid by a person other that yourself, and you want the reimbursement to be issued to this person, please provide the name and address of this person and sign below:

Name: JIN, JUN LE Relationship: son-in-law

Address

#, Street: 6# SHAUGHNESSY, CRESCENT Apt.: Telephone: 613.618-1057

City: OTTAWA Province: ONTARIO Postal Code: K2K 2P1

Patient's or Authorized Person's Signature: Junsheng wang **Date:** 2012-11-3

Send your claim form and your original bills or receipts to:

Global Excel Management Inc.
73, Queen Street
Sherbrooke (Québec) J1M 0C9

FOR COMPANY USE ONLY **Fraud Verification A:** **Fraud Verification B:**

Consent to Release of Information

I Jun Sheng Wang hereby authorize **Global Excel** to provide to and discuss with **Johnson Fu Insurance Agency Inc**. (the " Claims Assistant") all information and documentation, including medical and other personal information, provided by me or obtained by **Global Excel** from third parties (collectively, " records") regarding any matter for which I may make a claim to **Global Excel** under a policy of insurance. I understand that the purpose for the provision of records to and the discussion of records with the Claims Assistant is to enable **Global Excel** and insurers to determine whether and to what extent my claim may be covered by insurance and to facilitate communications about my claim. This authorization takes effect on the date set out below and may be revoked by me at any time in writing. If this authorization is revoked before the provision of records to and the discussion of records with the Claims Assistant, the assessment and processing of my claim may be delayed.

A copy of this authorization received by **Global Excel** shall be as effective and valid as the original.

Date : Nov 3, 2012 Insured's name: WANG, JUNSHENG
(Please Print)

Signed : Jun Sheng Wang
(Insured or authorized representative)

(Print name of authorized representative)

(Relationship to Insured)