# DENTAL EXPENSES CLAIM

the benefits trust

Forward claims to: THE BENEFITS TRUST
3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9
Phone: 905-264-8990, 1-800-487-2993 Fax: 905-264-1123

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

_____
Signature of Subscriber

| **PART 1** | **Dentist** Unique No. | **Patient** | | | |
|---|---|---|---|---|---|
| Name: | | Last Name: | | First Name: | |
| Address: | | Address: | | | |
| City, Prov: | | Apt. or Unit: | | City: | |
| Postal Code: | Telephone: | Province: | | Postal Code: | |

| Date of Service m m d d y y | Procedure Code | Intl. Tooth Code | Tooth Surface | Laboratory Charge | Dentist's Fee | Total Charge | For Plan Administrator Only: Eligible Amount | Not Covered | Code |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |
| | | | | | | 0.00 | | | |

This is an accurate statement of services performed and fees charged. E & OE.

Total Submitted Fee: $ 0.00

Office Verification / Dentist's Signature

Date: mm / dd / yy

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 cost of treatment. Signature of Subscriber:

## PART 2 COVERED EMPLOYEE / PLAN MEMBER

Complete this part before taking the form to your dentist's office.

1. Name of employer / contractholder — Group / Policy Number

2. Name of employee / subscriber — Certificate Number: — Birthdate: mm / dd / yy

3. If claim is for your dependent, indicate relationship — Patient's birthdate
   - ❑ spouse
   - ❑ child
   - ❑ other (specify)_____

   mm / dd / yy

4. If dependent is a child, age 21 or older, the name of the educational institute he / she is attending MUST be given below: — Full-time ❑ Part-time ❑

   _____

5. Are dental benefits payable for this claim from any other group insurance plan? Yes ❑ No ❑
   If "yes", indicate policy number and name of Insurer.

6. If any of the above treatment is required as the result of an accident, indicate date of accident and details.

7. Is any treatment for orthodontic purposes? Yes ❑ No ❑

8. If denture, crown or bridge, is this initial placement? Yes ❑ No ❑ If no, give date of prior placement or age and reason for replacement.

**Health Care Spending Account** (Expenses must be eligible under the Income Tax Act)

Do you want any part of this claim to be paid through your Health Care Spending Account? Yes ❑ No ❑

If Yes: 1) Please attach original receipts, or if expenses have been submitted under this or another plan and you are now claiming for the unpaid portion, please attach copies of the receipts, and the Explanation of Benefits from the previous submission.

2) Please indicate whether you want: All of the remaining portion of the claim to be paid ❑ or A specific amount ❑ $ _____

I hereby certify that the above information is true to the best of my knowledge and that these expenses were incurred by myself (or my dependants) for the exclusive use of the person for whom the expense was incurred, as indicated above. I authorize The Benefits Trust and its administrators to use my social insurance number for identification purposes in the handling of my claim. In addition, I also authorize my Employer and The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Claim Form and any other benefit related information contained in files regarding me or my dependants, now or in the future, for the purposes of administration and/or management of the Benefit Services Contract issued by The Benefits Trust. A photostatic or facsimile or carbon copy of this authorization shall be as valid as the original.

Signature of employee — Date