

Dental Claim Form



Approved by the Canadian Dental Association

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Dentist

P A T I E N T	Last Name	Given Name	Unique Number	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.
	Address Apt.		D E N T I S T	Phone No.:		
	City	Prov.		Postal Code		

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 \$ _____ 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.
	Signature of Patient (Parent/Guardian)
Duplicate Form <input type="checkbox"/>	Office Verification/Dentist's Signature

Date of Service			Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges
Day	Month	Year						
This is an accurate statement of services performed and the total fee due and payable E & OE						TOTAL FEE SUBMITTED		

For Plan Administrator Use Only

2 To be completed by Member

You must complete this section.

Member Information

Contract Number 25255 - BC Rail Ltd.	Member ID	Date of Birth	Day	Month	Year
Last Name	Given Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Street Address		Daytime Tel. No. ()			
City	Province	Postal Code	Evening Tel. No. ()		

3 Spouse and Children Covered by this Claim

Complete only if claim is for your spouse or child.

Spouse's Full Name		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth	Day	Month	Year
Child's Name	Relationship to you		Date of Birth			Complete for coverage dependents (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

4 Co - ordination of Benefits

Complete only if your Spouse and/ or children has coverage under any other dental plan or contract.

Is your spouse and/ or children covered for any of these expenses under any other dental plan or contract?	
No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	Spouse's date of birth: _____ Day Month Year
If yes:	
<ul style="list-style-type: none"> 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:	
Contract Number: _____	Member ID: _____
Do you want us to co-ordinate benefits (process both claims)?	
No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	
If yes, Spouse's Signature: _____	Date: _____ Day Month Year

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 <input type="checkbox"/> Yes <input checked="" type="checkbox"/>		If yes, complete the following:	
When and where did the accident occur? _____ Day / Month / Year		Work <input type="checkbox"/>	Home <input type="checkbox"/>
Other <input type="checkbox"/>		How did the accident occur?	
Are any expenses the result of a condition covered by a workers' compensation program? No <input type="checkbox"/> Yes <input type="checkbox"/>			
2. Is this treatment for: orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>		Implants? No <input type="checkbox"/> Yes <input type="checkbox"/>	
3. Crowns, Bridges, Dentures		Is this the initial placement? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If No, • Date of prior placement: _____ Day Month Year	• Reason for replacement: _____	If Yes, • Date teeth were extracted (for denture or bridge): _____ Day Month Year	
Please include the following to facilitate handling of your claim:		<ul style="list-style-type: none"> 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.

Fraudulent claims are very costly for all participants in benefit plans. As administrator of this plan, we may check the accuracy of the information given in support of your claim.

I certify that all goods or services being claimed have been received by me/my dependents. 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 assessing and paying a benefit, if any.

I certify that the information in this form is true and complete and does not contain a claim for any expenses previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administration and paying claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, insurers and reinsurers. I understand that for audits or administrative reporting, my plan sponsor may have access to statistical and financial information without any personal identifiers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member Signature _____	Date _____ Day Month Year / /
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For details specific to your plan, consult your benefit information package or visit our web site, www.sunlife.ca

Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims Office:

EASTERN REGION
Atlantic Canada, Quebec and Eastern Ontario

PO Box 6076 Stn CV
Montreal QC H3C 4S3
1 800 361-2128

CENTRAL REGION
Ontario (except Eastern Ontario)

PO Box 4023 Stn A
Toronto ON M5W 2P7
(416) 753-4300
1 800 361-6212

WESTERN REGION
Western Canada, N.W.T. and Yukon

PO Box 2880 Stn Main
Edmonton AB T5J 4S6
1 800 661-7334