Desjardins Financial Security™
life, health, retirement

Desjardins Financial Security Life Assurance Company
GROUP HEALTH CLAIMS
P.O. Box 4358, STN A, Toronto ON M5W 3M3

CLAIM FORM FOR DENTAL CARE EXPENSES

DENTIST

Name
Address
City, Province
Postal code
Telephone

Member number:

Last name of patient | First name (s)

Address | Apt.

City, Province

Postal code

* **To expedite your claim, please answer all the questions.**

IF GROUP IS SELF-ADMINISTERED
The administrator must complete this section before the insured fills out the form

In force	Individual	YY	MM	DD	Family	YY	MM	DD
	Other, specify					YY	MM	DD
TERMINATED						YY	MM	DD

Administrator's signature **Date**

TO BE COMPLETED BY THE MEMBER - Bank information for direct deposit (include specimen cheque marked "VOID" for first requests or changes only)

Name and address of the financial institution | Identification (transit) | Account number

Date of treatment Day Month Year	Tooth No.	Procedure code	Tooth surface	Laboratory expenses	Dentist's fees	Total charge	For insurer use only

IMPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer application, inlay or denture, please complete the reverse. If the treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date.

Total fee claimed: →

This section is reserved for the dentist's diagnosis.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED EXCEPT ERRORS AND OMISSIONS.

Signature of dentist _____ Date _____

HEALTH SPENDING ACCOUNT

Complete this section if you have this coverage (You may wish to coordinate benefits with your spouse's plan before using your health spending account)
Should the portion of expenses not covered under your contract be applied against your expense account? ☐ Yes ☐ No

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him. I authorize my dentist to disclose all the information appearing on this form to my insurance company or to one of its agents.

Signature of member | Date

I understand that i am responsible for the total cost of the treatment. I authorize my dentist to disclose all the information appearing on this form to my insurance company or to one of its agents.

Signature of member | Date

TO BE COMPLETED BY THE MEMBER

Patient's Date of birth YY MM DD

Full name of member

dfsalkidf:ls

Identification or certificate No. or S.I.N.

Policy or group or contract No.

Name of group or policyholder or employer

Relationship to the member ☐ Spouse ☐ Daughter ☐ Son ☐ Other

Complete only if you are claiming expenses incurred for your dependent children aged 18 or 21 or older (depending on the policy). Remember to include the information for the period in which the expenses were incurred for your child.

Full-time Student ☐ Yes ☐ No
From YY MM DD
To YY MM DD

Name of Educational Institution Attended

COORDINATION OF BENEFITS

The coordination of benefits may entitle you to a reimbursement of up to 100% of your expenses.

HOW TO SUBMIT A CLAIM WHEN THERE ARE TWO INSURERS

1. Spouses must submit their claim to their insurer and provide Desjardins Financial Security Life Assurance Company with the details on the benefits paid as well as the copies of the receipts.
2. Claims for dependent children must be submitted to the insurer of the parent whose birthday is the first in the year.

Is your spouse insured under another insurance contract that provides benefits for dental care?
☐ Yes ☐ No

If yes, is the coverage:
☐ individual ☐ family

EFFECTIVE DATE YY MM DD
TERMINATION DATE YY MM DD

Full name of spouse:

Date of birth YY MM DD

Name of insurer

Policy No. | Identification or certificate No.

ALL INFORMATION APPEARING ON THIS FORM IS CONFIDENTIAL.

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY THE MEMBER

Date of the accident | YY | MM | DD | Location of the accident: _____

How did the accident occur?

_____

_____

If the claims are the result of a work injury or a motor vehicule accident please note that the claim must first be submitted to your provincial automobile insurance or occupational health and safety plan before being forwarded to your insurer.

TO BE COMPLETED BY THE DENTIST

* PREOPERATIVE X-RAYS ARE REQUIRED FOR THE STUDY OF DENTAL CARE MADE NECESSARY AS THE RESULT OF AN ACCIDENT. THEY WILL BE RETURNED TO THE ATTENDING DENTIST AS SOON AS POSSIBLE.

Is it an accidental injury to a healthy and natural tooth? ☐ Yes ☐ No

Diagnosis and clinical description prior to the accident: _____

_____

_____

CLAIM FOR A DENTURE, VENEER APPLICATION, CROWN OR INLAY

Please include a copy of the bill from the commercial lab with your claim.

REMOVABLE DENTURE

Is this the first time such a denture has been inserted? ☐ Yes ☐ No

If it is, indicate the date on which the teeth replaced by the denture were extracted and the teeth numbers:

_____

_____

_____

If it is a replacement, by the same type of denture, please indicate:

A. The date of previous insertion: | YY | MM | DD |

B. What material was the old denture made of: _____

C. The reason of the replacement: _____

_____

FIXED BRIDGES — Please send us the appropriate x-rays taken prior to the treatment and x-rays showing the left and right sides

If it is the first time a fixed bridge was inserted, indicate:

A. The date the extracted teeth were replaced: _____

_____

B. The date of the previous insertion if the partial denture was replaced by a fixed bridge: | YY | MM | DD |

What material was the old denture made of: _____

C. List the missing teeth: _____

If it is to replace a fixed bridge, indicate:

A. The date of the previous insertion: | YY | MM | DD |

What material was it made of: _____

B. The reason of the replacement: _____

_____

CROWNS, VENEER APPLICATIONS, INLAYS — Please send the appropriate x-rays for the treated tooth taken before the treatment.

Is it the first insertion? ☐ Yes ☐ No

If it is a replacement, indicate:

A. The date of previous insertion: | YY | MM | DD |

B. The reason of the replacement: _____

_____

C. Add any details pertaining to the claim: _____

_____

Dentist's signature _____ Date | YY | MM | DD |