

Desjardins
Financial Security

□ 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

| The administrator wust complete this section before the insured fills out the form Individual Y | | | | | | 1 | | | | | | | | | | | | | | _ | | |
|--|------------------------|---|-------------|----------|----------|-----------|-----------|---------|----------|-----------|--------|-----------|---------------|---------|-------|---------------------|--------|------------|-----------|----------|--|--|
| To city, Province Postal code | | First name (s) | =111 | oi palie | | | | | | | | | | | | | | е | Name | | | |
| Postal code Postal code Postal code Postal code | Apt. | | | | ddress | A | | | | | | | | | | | | | | | | |
| Postal code | | | | ince | ty, Pro | G | | | er: | numb | mber | Me | | | | | | | • | i | | |
| The administrator must complete this section before the insured fills out the form In force In Individual | | | | le | ostal co | P | | | | | | | | | | | | | | | | |
| The administrator must complete this section before the insured fills out the form In force In Individual | r all the guestion | ur claim inlease answer all | * To expedi | | | | | | | | | | | | | | | | | <u>-</u> | | |
| In force Individual YY MM DD Family YY MM DD TERMINATED Date TERMINATED Date TO BE COMPLETED BY THE MEMBER - Bank information for direct deposit (includes specimen cheque marked "VOID" for first requests or changes only) Name and address of the financial institution Identification (transit) Account number Date of treatment Tenth Procedure Tooth Code Surface Date Date Date of treatment Tenth Procedure Tooth Code Surface Date Date Date Date of treatment Tenth Procedure Tooth Code Surface Date Date Date Date Date of treatment Tenth Procedure Tooth Code Surface Date Da | | TO BE COMPLETED BY THE | TO EXPEDI | | | | RED | STER | DMIN | ELF- | IS S | GROUP | IF | | | | | | | | | |
| TERMINATED Administrator's signature Date TO BE COMPLETED BY THE MEMBER - Bank information for direct deposit (includes specimen cheque marked 'VOID' for first requests or changes only). Date of treatment Tooth Procedure Tooth Laboratory Bentist's Total For insurer Identification or certificate No. Name and address of the financial institution Day Month Year No. Code Surface Expenses Bentist Surface Bentist Surface Bentist Surface Bentist Surface Bentist Surface Bentist Bentist | | Patient's Date of birth | า | ne form | s out | ured fill | e insu | ore th | n bef | secti | this | omplete | st c | mus | rator | nist | dmir | The ac | Т | | | |
| TERMINATED | DD | YY MM | DD | IM | | Y | | mily | Fa | DD | | MM | | Y | | al | ividu | Indi | | | | |
| 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 Date of treatment Tools Account number Account number Date of treatment Tools Procedure Tools Laboratory Dentist's Total For insurer use only Date of treatment Tools Procedure Tools Laboratory Dentist's Total For insurer use only Date of treatment Tools Procedure Tools Laboratory Dentist's Total For insurer use only Date of treatment Tools Procedure Tools Laboratory Dentist's Total For insurer use only Name of group or policyholder or committee to the part of the policy), Remember to the policy, Remember to the part of the policy of the part of the | | | DD | IM | | Y | | | | | | | | | ify | pec | ner, s | Oth | rce | fo | | |
| Administrator's signature TO BE COMPLETED BY THE MEMBER - Bank information for direct deposit (include specimen cheque marked 'Volto' for first requests or changes only) Date of treatment Tooth Procedure Tooth Laboratory Dentist's Total For insurer | nber | | DD | IM | | Y | | | | | | NATED | RMI | TEF | | | | | | | | |
| This section is reserved for the definits's diagnosis. This section is reserved for the definits overage (You may wish to coordinate benefits with your spouse suspense account? Yee, spouse to he is sure of expense or covered under your contract of the spouse the first in the year. This section is reserved for the definits overage (You may wish to coordinate benefits with your spouse is susted under an account of expense or chief to pay the thirty of the treatment and the first pay as and on the period of expense or chief to the coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or coverage (You may wish to coordinate benefits with your spouse is susted under an account of expense or covered under your contract be applied against your expense account? Yee Yee | No. of CLNI | | J. | | ate | D | | | | | | | | | ure | nat | s sig | ator's | ninistr | Adn | | |
| Name and address of the financial institution Identification (transit) Account number | No. or S.I.N. | Identification or certificate No. | marked | cheque | ecimer | nclude s | posit (ir | rect de | n for di | ormati | nk int | BER - Bai | ЕМЕ | ЕМ | Y TH | D B | ETE | MPLI | E CO | TO E | | |
| Date of treatment Tooth Procedure Tooth Surface Suprises Dentist's Total For insurer Use only | | | | | 1 | only) | anges (| s or ch | request | for first | OID" | "VC | | | | | | | | | | |
| Date of treatment Tooth Procedure Tooth Code Surface Dentist's Total For insurer use only | itract No. | Policy or group or contract | Hamber | tocount | | (transit) | ication | identii | | | | | | | | | 0 0. 1 | | , aa a | | | |
| Date of treatment Tooth Procedure Tooth Code Surface Dentist's Total For insurer use only | | | | | | | | | | | | | | | | | | | | | | |
| Day Month Year Day Month Year No | der or employer | Name of group or policyholder o | | | - | | | | \ | | Υ_ | | $\overline{}$ | | - | $\overline{\gamma}$ | Υ | mant | of troots | Doto | | |
| Spouse | | | | | | | | | | | | | | | | | | | | | | |
| member | _ | he Douse | | | | | | | | Т | | | | Т | П | | | | | | | |
| for your dependent children aged it depending not he policy). Remember information for the period in which were incurred for your child. From | Other | mber L Son | | | | | | | | | | | | | | | | | | | | |
| information for the period in which were incurred for your child. Full-time Student From Yes No To Yes No Name of Educational Institution Atter COORDINATION OF BEP The coordination of benefits may be reimbursement or up to 100% of you Hours up to 100% | ed 18 or 21 or older | your dependent children aged 18 | | | | | | | | | | | | | H | | | | | | | |
| Yes No To Yes No To Yes No Name of Educational Institution Atter | | rmation for the period in which | | | | | | | | | | | | | | | | | | | | |
| Name of Educational Institution Atter COORDINATION OF BEN | YY MM DD | / DN- | | | 1 | | | | | | | | | | Ш | | | | | | | |
| COORDINATION OF BEN The coordination of benefits may e reimbursement of up to 100% of you HOWTO SUBMIT A CLAIM WHEN: TWO INSURERS 1. Spouses must submit their claim and provide Desjardins Financies and provide Desjardins Financies and provide Desjardins Financies and provide Desjardins Financies. 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 Coordination of benefits may e reimbursement of up to 100% of you how their claim and provide Desjardins Financies Assurance Company with the rebenifits paid as well as the cobenifits paid as well as the cobenifits paid as well as the cobenifits paid as well as the collection of the insurer of the parent who to the insurer of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deal of the first in the year. Is your spouse insured under and contract that provides benefits for deal of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deal of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deal of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deal of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deal of the year. Is your spouse insured under and contract that provides benefits for deal of the year. Is your spouse insured under and contract that provides benefits for deal of the year. Is your spouse insured under and contract that provides benefits for deal of the year. Is your spouse insured under and contract that provides benefits for deal of the year. Is your spouse insured under and contract that provides benefits as year. Is yes in the course of the parent who the testiment who the treatment is a year. It was not dentile the year. Is your | | 10 | | | | | | | | | | | | | Ш | | | | | | | |
| The coordination of benefits may e reimbursement of up to 100% of you How TO SUBMIT A CLAIM WHEN: TWO INSURERS In Spouse must submit their claim and provide Desjardins Financia Session, the date of the date on which the treatment requires more than one session, the date of the date on which the treatment reminates or the insertion date. 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 Onder the dentist of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under and contract that provides benefits with your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under your contract benefits with your year. Is your spouse insured under your contract benefits with your year. In individual family | , monada | | | | | | | | | | | | | | | | | | | | | |
| The coordination of benefits may e reimbursement of up to 100% of you How TO SUBMIT A CLAIM WHEN: TWO INSURERS In Spouse must submit their claim and provide Desjardins Financia Session, the date of the date on which the treatment requires more than one session, the date of the date on which the treatment reminates or the insertion date. 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 Onder the dentist of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep dentity and the first in the year. Is your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under and contract that provides benefits with your spouse insured under and contract that provides benefits for deep land to the parent who the first in the year. Is your spouse insured under your contract benefits with your year. Is your spouse insured under your contract benefits with your year. In individual family | | | | | | | | | | | | | | | | | | | | | | |
| MPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer pplication, inlay or denture, please complete the reverse. If the treatment requires more than one assign, the date of the deade on which the treatment treminates or the insertion date. 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 | BENEFITS | COORDINATION OF BEN | | | | | | | | | | | | | | | | | | | | |
| MPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer opplication, injug or denture, please complete the reverse. If the treatment requires more than one session, the date of treatment requires more than one session, the date of treatment must be the date on which the treatment terminates or the insertion date. This section is reserved for the dentist's diagnosis. 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 | | | | | | | | | | | | | | | | | | | | | | |
| MPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer oplication, 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 requires more than one session, the date of treatment must be the date on which the treatment requires more than one session, the date of treatment must be the date on which the treatment reminates or the insertion date. 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 | • | W TO SUBMIT A CLAIM WHEN T | | | | | | | | | | | | | | | | | | | | |
| MPORTANT: If the claim is for dental care subsequent to an accident, a crown, veneer optication, 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. This section is reserved for the dentist's diagnosis. 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 | laim to their insurer | | | | | | | | | | | | | | П | | | | | | | |
| benefits paid as well as the copies season, the date of treatment must be the date on which the treatment terminates or the insertion date. This section is reserved for the dentist's diagnosis. 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 | ancial Security Life | and provide Desjardins Financia | | | | | | | | | | | | | | | | | | | | |
| to the insurer of the parent who the first in the year. Is your spouse insured under and contract that provides benefits for de yes. No If yes, is the coverage: individual individual family EFFECTIVE DATE TERMINATION DATE | opies of the receipts. | benefits paid as well as the copies | | | ea: 🖚 | ee ciain | Otal IE | | | | | | | | | | | | | | | |
| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED EXCEPT ERRORS AND OMISSIONS. Signature of dentist | | Claims for dependent children mus to the insurer of the parent who | | | | | | | | | | agnosis. | 's dia | entist' | the d | d for | serve | n is res | section | This | | |
| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED EXCEPT ERRORS AND OMISSIONS. Signature of dentist | | | | | | | | | | | | | | | | | | | | | | |
| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED EXCEPT ERRORS AND OMISSIONS. Signature of dentist | | | | | | | | | | | | | | | | | | | | | | |
| Signature of dentist | | Yes No | | | | | | | | | | | | | | | | | | | | |
| Signature of dentist | | es, is the coverage: | RORS AND | PT ERR | D EXC | CHARGE | EES C | AND F | RMED | PERFO | CES | OF SERVIC | NT C | EME | STAT | TE | URA | | | | | |
| 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? I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the treatment. I authorize my dentist to disclose all the | | individual amily | | | | | | | | | | | | | | | | 3 . | | | | |
| 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? I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the treatment. I authorize my dentist to disclose all the | MM DD | ECTIVE DATE YY MM |] | | | Date _ | | | | | | | | | | | | | | | | |
| 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? I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to the treatment. I authorize my dentist to disclose all the | MM DD | RMINATION DATE YY MM | | | | | | | | | | | | | | | | | | | | |
| above named dentist and authorize payment directly to the treatment. I authorize my dentist to disclose all the | | name of spouse: | | | • | | | | | ount) | acc | spending | alth | ur he | ng yo | usir | fore | lan be | se's p | spou | | |
| above named dentist and authorize payment directly to the treatment. I authorize my dentist to disclose all the | DD | e of birth YY MM DD | | | | | | | | | | | | | | | | | | | | |
| him. I authorize my dentist to disclose all the informal information appearing on this form to my insurance Name of insurer | | o or birtin | | | | | | | | | | | | | | | | | | | | |
| tion appearing on this form to my insurance company or to one of its agents. | | | | y | | | | | | | | | | | | s fo | n thi | ring o | appea | tion | | |
| Policy Idea | Identification | | | | | | | | | | | | | | | | gent | a(| JIE U | J. 10 | | |
| No. or cer | or certificate No. | No. or cer | | | | | | | | _ _ | | | | | | | | | | | | |
| Signature of member Date Signature of member Date | | | Date | I | | nember | ire of m | Signatu | | | | Date | | | er | emb | of m | nature | Sig | | | |

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY THE MEMBER

| Date of the accident How did the accident occur? Coation of the accident Coation of the accident | |
|---|---|
| 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 proving automobile insurance or occupational health and safety plan before being forwarded to your insurer. BE COMPLETED BY THE DENTIST PRECOPERATIVE 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? | Date of the accident YY MM DD Location of the accident: |
| BE COMPLETED BY THE DENTIST REOPERATIVE 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: Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical description prior to the accident: No Diagnosis and clinical denture made of: No Diagnosis and clinical denture made of: No Diagnosis and clinical to the previous insertion No Diagnosis and clinical | |
| BE COMPLETED BY THE DENTIST PREOPERATIVE X-RAYS ARE REQUIRED FOR THE STUDY OF DENTAL CARE MADE NECESSARY AS THE RESULT OF AN CCIDENT. THEY WILL BE RETURNED TO THE ATTENDING DENTIST AS SOON AS POSSIBLE. Is it an accidental injury to a healthy and natural tooth? | |
| BE COMPLETED BY THE DENTIST PREOPERATIVE X-RAYS ARE REQUIRED FOR THE STUDY OF DENTAL CARE MADE NECESSARY AS THE RESULT OF AN OCCIDENT. THEY WILL BE RETURNED TO THE ATTENDING DENTIST AS SOON AS POSSIBLE. Is it an accidental injury to a healthy and natural tooth? | |
| REOPERATIVE X-RAYS ARE REQUIRED FOR THE STUDY OF DENTAL CARE MADE NECESSARY AS THE RESULT OF AN OCIDENT. THEY WILL BE RETURNED TO THE ATTENDING DENTIST AS SOON AS POSSIBLE. Is it an accidental injury to a healthy and natural tooth? | |
| REOPERATIVE 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? | |
| REOPERATIVE X-RAYS ARE REQUIRED FOR THE STUDY OF DENTAL CARE MADE NECESSARY AS THE RESULT OF AN CCIDENT. 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: | E COMPLETED BY THE DENTIST |
| Is it an accidental injury to a healthy and natural tooth? Yes No Diagnosis and clinical description prior to the accident: | |
| Diagnosis and clinical description prior to the accident: | |
| AIM FOR A DENTURE, VENEER APPLICATION, CROWN OR INLAY se 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? | s it an accidental injury to a healthy and natural tooth? Yes No |
| 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: | Diagnosis and clinical description prior to the accident: |
| 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: Y 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: What material was it made of: 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: | |
| 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: Y 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: What material was it made of: 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: | |
| 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: Y 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: What material was it made of: 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: | |
| REMOVABLE DENTURE Is this the first time such a denture has been inserted? | |
| Is this the first time such a denture has been inserted? | · · · · · · · · · · · · · · · · · · · |
| 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: 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 of the previous insertion if the partial denture was replaced by a fixed bridge: 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: 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: | |
| A. The date of previous insertion: | f it is, indicate the date on which the teeth replaced by the denture were extracted and the teeth numbers: |
| A. The date of previous insertion: | |
| A. The date of previous insertion: | |
| A. The date of previous insertion: | |
| 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: 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: 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: | f it is a replacement, by the same type of denture, please indicate: |
| 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: 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: 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: | A. The date of previous insertion: YY MM DD |
| 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: 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: 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: | • |
| 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: 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: 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: | |
| 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: 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: 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: | |
| 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: 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: 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: | TIVED BRIDGES — Bloom conduct the appropriate v. rave taken prior to the treatment and v. rave showing the left and right eiden |
| 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: 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: 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: | |
| B. The date of the previous insertion if the partial denture was replaced by a fixed bridge: 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: 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: | |
| 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: 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: | A. The date the extracted teeth were replaced. |
| 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: 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: | |
| C. List the missing teeth: If it is to replace a fixed bridge, indicate: A. The date of the previous insertion: 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: | |
| If it is to replace a fixed bridge, indicate: A. The date of the previous insertion: 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: | |
| A. The date of the previous insertion: 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: | • |
| 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? | |
| 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? | A. The date of the previous insertion: |
| CROWNS, VENEER APPLICATIONS, INLAYS — Please send the appropriate x-rays for the treated tooth taken before the treatment. Is it the first insertion? | What material was it made of: |
| Is it the first insertion? | 3. The reason of the replacement: |
| Is it the first insertion? | |
| Is it the first insertion? | CROWNS, VENEER APPLICATIONS, INLAYS — Please send the appropriate x-rays for the treated tooth taken before the treatment. |
| If it is a replacement, indicate: A. The date of previous insertion: YY MM DD | |
| A. The date of previous insertion: YY MM DD | |
| | |
| B. The reason of the replacement: | A. The date of previous insertion: |
| | 3. The reason of the replacement: |
| | |
| C. Add any details pertaining to the claim: | C. Add any details pertaining to the claim: |
| | |