



Firm #

Certificate #

G R O U P D E N T A L C L A I M

Please print. The Dentist completes shaded area. The Employee completes all other sections except the Patient's Declaration which should be signed by the person who received the dental treatment. All the information you provide on this form will be treated as confidential. Complete all applicable parts of the form or your claim may take longer to process.

Chambers of Commerce Group Insurance Plan, 582 King Edward Street, Winnipeg, Manitoba R3H 0P1

Unique #, Spec., Patient's Office Account #, Last Name, Given Name(s), Home Address, City, Province, Postal Code, Phone Number

Table with columns: DATE OF SERVICE (DAY, MO., YR.), PROCEDURE CODE, INTL. TOOTH CODE, TOOTH SURFACES, DENTIST'S FEE, LABORATORY CHARGE, TOTAL CHARGES, FOR DENTIST'S USE, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

TOTAL FEE SUBMITTED

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

Dentist's Signature

OPTIONAL ASSIGNMENT OF BENEFITS

I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist.

Employee's Signature

PATIENT'S DECLARATION

I understand that the fees listed in this claim may not be covered by or may exceed 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 form to the insurance company and its agents.

Patient's Signature (or Parent's/Guardian's)

- 1. Employee's Name and Address (if different from the Patient's above)
Firm Name
2. Employee's birthdate (D/M/Y)
3. The Patient is the [] Employee [] Employee's spouse [] Employee's child
Spouse's birthdate (D/M/Y)
Child's birthdate (D/M/Y)
[] Male [] Female
4. Do you have other dental coverage? [] No [] Yes
If Yes, Employer's Name
Insurer's Name and Address
Policy Number
5. If the Patient is a: child, does the child live with you? [] No [] Yes
child over 18, is the child a full time student? [] No [] Yes
child over 18, is the child employed? [] No [] Yes
School Name
Hours worked per week
6. Is this dental treatment as a result of an accident? [] No [] Yes
If Yes, provide the date, place and details of the accident
7. Is this treatment a denture, crown or bridge? [] No [] Yes
An initial placement? [] No [] Yes
If a replacement, provide the last placement date and reason for placement
8. Is this treatment for orthodontic purposes? [] No [] Yes

I authorize the release of any information or record requested in respect of this claim to the Insurer and its agents, and I certify that the information provided on this form is true, correct and complete to the best of my knowledge.

Employee's Signature

Date