Chambers of Commerce Group Insurance Plan®

Please print your Firm & Certificate #

Firm #	Certificate #

DENTAL ACCIDENT CLAIM

PART 1. DENTIST

DENTIST

Name

Address

City, Province

Postal Code

Telephone

Social Ins. Number

PATIENT

Last Name

Given Name(s)

Home Address

City

Province

Postal Code

DATE OF SERVICE DAY	MO.	YR.	INTL. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL CHARGE

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

Dentist's Signature

Date (D/M/Y)

TOTAL SUBMITTED FEE

For Dentist's use only. For additional information re: diagnosis, procedures, or complications, and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

Signature of Patient (or Parent/Guardian)

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

Signature of Subscriber

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of damage

2. Is further treatment indicated? ❑ No ❑ Yes If Yes, please describe.

INT. TOOTH CODE	TREATMENT INDICATED – USE PROCEDURE CODE IF POSSIBLE	ESTIMATED DATE OF TREATMENT DAY	MONTH	YEAR

3. Describe further potential problems and indicate time frame

Date (D/M/Y)

Dentist's Signature

ALL THE INFORMATION YOU PROVIDE ON THIS FORM WILL BE TREATED AS CONFIDENTIAL.

PART 3. EMPLOYEE'S STATEMENT

Employee's Full Name ______________________________

Employee's Full Address ______________________________

City ____________________ Province ____________________ Postal Code ____________

Employee's Birthdate (D/M/Y) ____________________

Please provide date of accident ____________________ 20 ______ at ____________ a.m./p.m. ______

Where did it happen? ______________________________

How did it happen? ______________________________

____

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____

____

Date of first treatment ______________________________

Birthdate (D/M/Y) ____________________

Relationship to the insured ______________________________

If claim is for a dependent, who is age 21 or over, please provide the name of the school and date the patient last attended on a full-time basis.

Name of school ____________________ Date last attended (D/M/Y) ____________________

Are any dental benefits or services provided under any other group insurance or dental plan? ❑ Yes ❑ No

If Yes, Policy No. ____________________ Name of Insurer ____________________

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.

Date ____________________ Employee's Signature ____________________

Once completed, please mail to:
Chamber of Commerce Group Insurance Plan
582 King Edward Street, Winnipeg, MB R3H 0P1

THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM.