

PART 1 DENTIST						UNIQUE NO.	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.
P A T I E N T	LAST NAME			GIVEN NAME			D E N T I S T	SIGNATURE OF SUBSCRIBER	
	ADDRESS			APT.					
CITY		PROV.	POSTAL CODE				PHONE NO.		
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.			
DUPLICATE FORM <input type="checkbox"/>						I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.			
						SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____			
DATE OF SERVICE		PROCEDURE CODE		INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	INSTRUCTIONS
DAY	MO.	YR.							All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims. 1. Have your dentist complete Part 1. 2. Employee completes Parts 2 and 3. 3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee. 4. Send this claim to: Winnipeg Benefit Payments P.O. Box 3050 Winnipeg MB R3C 0E6 Toll Free: 1-800-957-9777 Or: (204) 942-3589 For the deaf or hard of hearing: Toll Free: 1-800-990-6654 Or: (204) 946-7281
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.						TOTAL FEE SUBMITTED			

PART 2 EMPLOYEE INFORMATION		
Plan Number 51801	Division Number _____	Employee Identification Number _____
Plan Name CARLETON UNIVERSITY		
Employee Name _____		Date of birth ____ / ____ / ____ Day Month Year
Employee address _____		
At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.		
Employee's Signature _____		Date _____

PART 3 COORDINATION OF BENEFITS	
1. Patient's relationship to you _____	2. Patient's date of birth ____ / ____ / ____ Day Month Year
3. If the patient is a child, does the patient reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. If the child is over 18: a) Is he/she a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b) If student, how many hours per week at school? _____	
c) Is he/she employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours worked per week? _____	
5. a) Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member insured _____ Relationship to employee _____	
Name of other insurance company _____ Policy Number _____	
b) Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____ / ____ / ____ Day Month Year	
6. Is this treatment required as the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, give date, location, and explain how accident happened _____	
7. Is a claim being made for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. If claim is for denture, crown or bridge, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give date of prior placement and reason for replacement.	

