THE EMPIRE LIFE INSURANCE COMPANY

STANDARD DENTAL CLAIM FORM

Approved by the Canadian Dental Association

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.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

DUPLICATE FORM ☐

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.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

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

FOR CARRIER USE

Administrator:
Please retain yellow copy and mail white copy to:

J&D Benefits Administration Ltd.
8901 Woodbine Ave., Suite 228
Markham, ON L3R 9Y4

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. A separate form is required for each person for whom a claim is being made.
2. Have Part 1 Dentist Statement completed and returned to you.
3. Fully complete all questions in Part 2 for Subscriber and Dependants.
4. Return form to your Plan Administrator when completed. Additional forms are available from your Personnel Office/Plan Administrator.

We strongly recommend that if charges will be $300.00 or more your claim be submitted for predetermination of benefits before the work is started. The submission of xrays will be required for crowns or bridge work. These will be returned promptly to your dentist.

PART 2 INSURED/SUBSCRIBER

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

Patient: relationship to Subscriber Date of Birth

Is he/she employed? No☐ Yes☐ - Where? # Hrs. Worked

Is he/she wholly dependent on you for support? No☐ Yes☐

If child age 21 or over, indicate if Student: Full time ☐ Part time ☐ if Handicapped ☐

If student, indicate school

Are any dental benefits or services provided under any other Group Insurance or Dental Plan? No☐ Yes☐ Policy No.

Name of Insuring Agency

If yes, provide spouse's Date of Birth
and Subscriber's Date of Birth

If denture, crown or bridge, is this initial placement? No☐ Yes☐
Give date of prior placement and reason for replacement

Is any treatment for orthodontic purposes? No☐ Yes☐

Is any treatment required as the result of an accident? No☐ Yes☐
Give date and details

I authorize:

1. the release of any information or records requested in respect of this claim to The Empire Life Insurance Company, its authorized representatives or its consultants and certify that the information given is true, correct and complete to the best of my knowledge, and
2. The Empire Life Insurance Company to release any statistical information regarding claims paid on behalf of me and my eligible dependants, other than specific details relating to a medical condition, to my employer.

A photocopy of this authorization should be as valid as the original.

Date (Day Month Year) Subscriber's Signature

PART 3 POLICY OWNER/EMPLOYER

Group Policy No. Division No. Employer

Cert. No. Name of Subscriber

Date Insured Date Dependant Insured Date terminated

Is claim being made for Workers' Compensation Benefits? No☐ Yes☐

Authorized signature Telephone No. Date (Day Month Year)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL