Co-operators Life Insurance Company
1920 College Avenue, Regina, SK S4P 1C4

DENTAL CLAIM FORM

PART 1 DENTIST

PATIENT

LAST NAME

GIVEN NAME

UNIQUE NO | SPEC | PATIENT'S OFFICE ACCOUNT NO.

DENTIST:

PHONE NO:

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

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

DUPLICATE FORM ❑

DENTIST: INDICATE ALL MISSING TEETH

18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38

DATE OF SERVICE			PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SUR-FACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						
					TOTAL FEE SUBMITTED			

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

OFFICE VERIFICATION X ______________________

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) X ______________________

PART 3 EMPLOYER/POLICYHOLDER

Please Return To:

GROUP LOCKHART
195 Dufferin Anvue
Suite 450
London, Ontario
N6A 1K7

FOR CERTIFICATION

PART 2 EMPLOYEE / MEMBER STATEMENT (Please Print)

Group No.	Account No.	PID#	Employers Name/Policyholder Name:

1. Employee's/Member's name ______ (first, initial, last) Previous surname (if applicable) ______
2. Employee's/Member's mailing address ______ (Street, City, Prov., Postal Code)
3. Employee's/Member's date of birth D | M | Y
4. Is this your first employee benefits claim with The Co-operators? ❑ No ❑ Yes
5. Are you actively at work? ❑ No ❑ Yes If NO are you ❑ Disabled? ❑ Retired?
6. Are dental benefits payable for this claim from any other company or source ❑ No ❑ Yes
   If YES name company and source ______ Spouse's date of birth D | M | Y
7. Is any treatment due to an accident? ❑ No ❑ Yes. If YES give dates and details on separate paper
8. Is any treatment for orthodontic purposes? ❑ No ❑ Yes
9. If treatment is for crowns, bridge or denture, complete the following questions.
   Is this initial placement ❑ No ❑ Yes. If NO provide previous placement date D | M | Y
   If initial denture or bridge, provide dates that teeth were extracted D | M | Y
10. Which family member are expenses for? ❑ employee ❑ spouse ❑ son ❑ daughter ❑ other (specify) ______
    if spouse or child complete the following information:
    Dependent's date of birth D | M | Y Is dependent ❑ student ❑ handicapped ❑ other (specify) ______
    If patient is a student over the age 21, name of school ______. Student status: ❑ Full-time ❑ Part-time ❑ Correspondence. Enrolled in the semester starting ______ (date) and ending ______ (date). Will student be graduating at the end of the semester indicated? ❑ Yes ❑ No

I understand that Co-operators Life Insurance Company is committed to the protection of privacy and security of the personal information provided in connection with this claim and that the submission of false or incomplete information may cause delay or denial of this claim. The information I have provided is complete and accurate and I authorize any person or organization with information relevant to this claim to release that information as may be required for the investigation and administration of this claim. I confirm that I am authorized to act on behalf of the person for whom this claim is made. Any copy of this authorization shall be as valid as the original.

______________________ ______________________

INCOMPLETE INFORMATION WILL MEAN A DELAY IN THE PROCESSING OF THE CLAIM. PLEASE MAKE SURE EVERYTHING IS COMPLETE AND ACCURATE. RETURN COMPLETED FORM TO: GROUP LOCKHART FOR CERTIFICATION.