Standard Life

Claim form

Dental

Claims department
Montréal
PO Box 900, Post STN B
Montréal, Québec H3B 3K5

Reset

Dentist (please print)

Patient		Dentist		
Surname		Unique no.	Spec.	Patient's office account no.
Given name(s)	Initial			
Main residence address (no., street)	Apt.			
City		Telephone no.		
Province	Postal code	For dentist's use only – for additional information, diagnosis, procedures, or special consideration.		

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

Signature of subscriber

☐ 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. 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 Y Y Y Y M M D D

Date of service	Procedure code	Intl. tooth code	Tooth surface	Dentist's fee	Laboratory charge	Total charges	Office verification
Y Y Y Y M M D D							
Y Y Y Y M M D D							
Y Y Y Y M M D D							
Y Y Y Y M M D D							
Y Y Y Y M M D D							
Y Y Y Y M M D D							
Y Y Y Y M M D D							
This is an accurate statement of services performed and the total fee due and payable, E & OE.				**Total fee submitted**			

In the case of major services, please have your dentist complete the back of the form.
In the case of dental accident, please complete Dental claim form – accidental injury to natural teeth G2119.

Participant statement - Part 1 (please complete part 1 and 2)

Policyholder name | Policy no. | Certificate no.

Participant surname | Given name(s) | Initial

Date of birth Y Y Y Y M M D D Language ☐ English ☐ French Gender ☐ M ☐ F

Patient

Patient name | Relationship to participant

If your child has reached the age limit specified in the contract, please complete below:

Handicaped ☐ Yes ☐ No **Student** ☐ Yes ☐ No ☐ Full time ☐ Part time Date of birth Y Y Y Y M M D D

Name of the attended school | Telephone no. of institution

Attendance period Start Y Y Y Y M M D D End Y Y Y Y M M D D

Student's status: The Standard Life Assurance Company of Canada reserves the right to confirm student status with the educational institution.
Disabled child: If a child is over the dependent child age limit under your contract and was permanently disabled while considered a covered dependent, please submit the form Application for total and permanent disability status for a dependent child PC GE10352 completed by you and the physician.

Please see reverse.

Coordination of benefits - Part 2

With the coordination of benefits, you can obtain a reimbursement of up to 100% of your expenses.

Is your spouse covered under an insurance plan with his/her employer? ☐ Yes ☐ No

If yes, please provide the following details:

Name of group dental care insurer | Policy no.

Spouse's type of coverage ☐ Family ☐ Single | Spouse's date of birth Y Y Y Y M M D D

Signature of participant | Telephone no. | Date Y Y Y Y M M D D

Plan with Health Spending Account (if applicable)

Do you want any unpaid portion of this claim to be considered under your Health Spending Account? ☐ Yes ☐ No

Note: The coordination of benefits guidelines will apply. If your Health Spending Account provides for automatic reimbursement, any unpaid portion will be paid from your Health Spending Account, subject to remaining credits.

Removable prosthesis

Is this an initial placement ? ☐ Yes ☐ No | If yes, indicate the extraction date for the replaced teeth. | Date Y Y Y Y M M D D

In case of a replacement, please indicate

a) The date of prior placement: | Date Y Y Y Y M M D D

b) The reason for replacement

Fixed bridges

Please forward pre-treatment panoramic or bitewing X-rays of left and right side. If this is an initial placement, please indicate:

a) The extraction date of the replaced tooth/teeth: | Date Y Y Y Y M M D D

b) The date of prior placement, if a removable partial denture is replaced by the bridge: | Date Y Y Y Y M M D D

c) Indicate all missing teeth

If this is a replacement, please indicate

a) The date of prior replacement: | Date Y Y Y Y M M D D

b) The reason for replacement

Crowns, veneers, onlays

Please forward periapical X-ray of the tooth taken prior to the treatment

Is this the initial placement? ☐ Yes ☐ No

a) The date of prior replacement: | Date Y Y Y Y M M D D

b) The reason for replacement

c) Pertinent details concerning the treatment

Dentist

Signature of dentist | Date Y Y Y Y M M D D