Chambers of Commerce Group Insurance Plan®

JG98-CH

DENTAL CLAIM

Please print your Firm & Certificate #

Firm #	Certificate #

Unique # _____ **Spec.** _____ **Patient's Office Account #** _____

DENTIST

Phone Number

PATIENT

Patient's Name _____

Home Address _____

City _____

Province _____ Postal Code _____

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

This is an accurate statement of services performed and the total fee due and payable, errors and omissions excepted. **Dentist's Signature** _____

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

OPTIONAL ASSIGNMENT OF BENEFITS

I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist.

Employee's Signature _____

1. **Name of Employer** _____
2. Name and address of Employee _____

   _____ Employee's birthdate (M/D/Y) _____
3. Patient's relationship to Employee _____ Patient's birthdate (M/D/Y) _____
4. Are you or your dependents entitled to benefits under any other plan? ☐ No ☐ Yes If "Yes," family member insured _____

   Name of insuring company _____ Spouse's birthdate (M/D/Y) _____
5. Are any of the services provided as a result of an accident? ☐ No ☐ Yes

   If "Yes," provide the date and details of the accident. _____
6. Are you claiming for a dependent child who is age 21 or older? ☐ No ☐ Yes

   Child is ☐ physically/mentally handicapped (medical evidence may be requested)

   ☐ a student enrolled **full time** at (school's name) _____
7. If treatment is a denture, crown or bridge, is it an initial placement? ☐ No ☐ Yes

   If "No," provide the last placement date and reason for replacement. _____
8. Is any treatment required for orthodontic purposes? ☐ No ☐ Yes

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

Insuring Company: Desjardins Financial Security

DENTAL CLAIM

INSTRUCTIONS (Please read carefully)

The Dentist completes shaded areas. The Employee completes all other sections.
Please ensure all questions are answered or your claim may take longer to process.
Send completed claim form to:

Chambers of Commerce Group Insurance Plan
582 King Edward Street
Winnipeg, Manitoba R3H 0P1

WANT TO GET YOUR CLAIM PAID FASTER?
SIGN UP FOR DIRECT DEPOSIT!

Receive your claim payments faster with direct deposit.

- Go to **www.my-benefits.ca** and register for the Plan member secure site
- Once you've registered, or if you're already registered, log in and select **DIRECT DEPOSIT** under **YOUR PROFILE** from the menu on the left
- Enter your banking information