Group Life & Health

Dental claim form – accidental injury to natural teeth

STANDARD LIFE

Claims department

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Toronto
PO BOX 69510
Toronto, Ontario M2M 4K3

Montréal
CP/PO BOX 900, SUCC/POST STN B
Montréal, Québec H3B 3K5

Participant statement

1. Policyholder name | Policy no. | Certificate no.

Participant surname	Given name(s)	Initial	Maiden name *(if different)*

Address *(no., street)*

City	Province	Postal code

Date of birth *(YYYY / MM / DD)* / /

Language : ❑ English ❑ French

Gender: ❑ M ❑ F

2. If services are for a dependent, please indicate:

Surname	Given name(s)	Relationship to participant

If your child has reached the age limit specified in the contract:

Handicaped: ❑ Yes ❑ No

Student: ❑ Yes ❑ No ❑ Full time ❑ Part time

Name of the attended school

Date of birth *(YYYY / MM / DD)*	Attendance period		Telephone no. of institution
	Start *(YYYY / MM / DD)*	End *(YYYY / MM / DD)*	
/ /	/ /	/ /	( )

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.*

3. Is your spouse covered under an insurance plan with his/her employer? ❑ Yes ❑ No
If yes, please provide the following:

Name of group dental care insurer	Policy no.
Spouse's type of coverage: ❑ Family ❑ Single	Spouse's date of birth *(YYYY / MM / DD)* / /

4. Please give the following information:

Date accident occurred *(YYYY / MM / DD)* / /	Place accident occurred

Circumstances of the accident: ______________________________

Date of first treatment *(YYYY / MM / DD)* / /	Who gave treatment:

Does patient's have school insurance? Yes ❑ No ❑

Is a claim being made to the WCB? Yes ❑ No ❑

5. *I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Standard Life, for the assessment of my claim.*

I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life or their authorized agents use the information provided in this form and prior claims under the same plan (if relevant) for the management of my claim and for statistical reports.

I confirm being authorized by my dependents to act on their behalf for their expenses submitted in this claim.

I consent to the use of my social insurance number as my certificate number, and understand that it is my responsibility to contact my employer/plan administrator if I prefer to use another identification number.

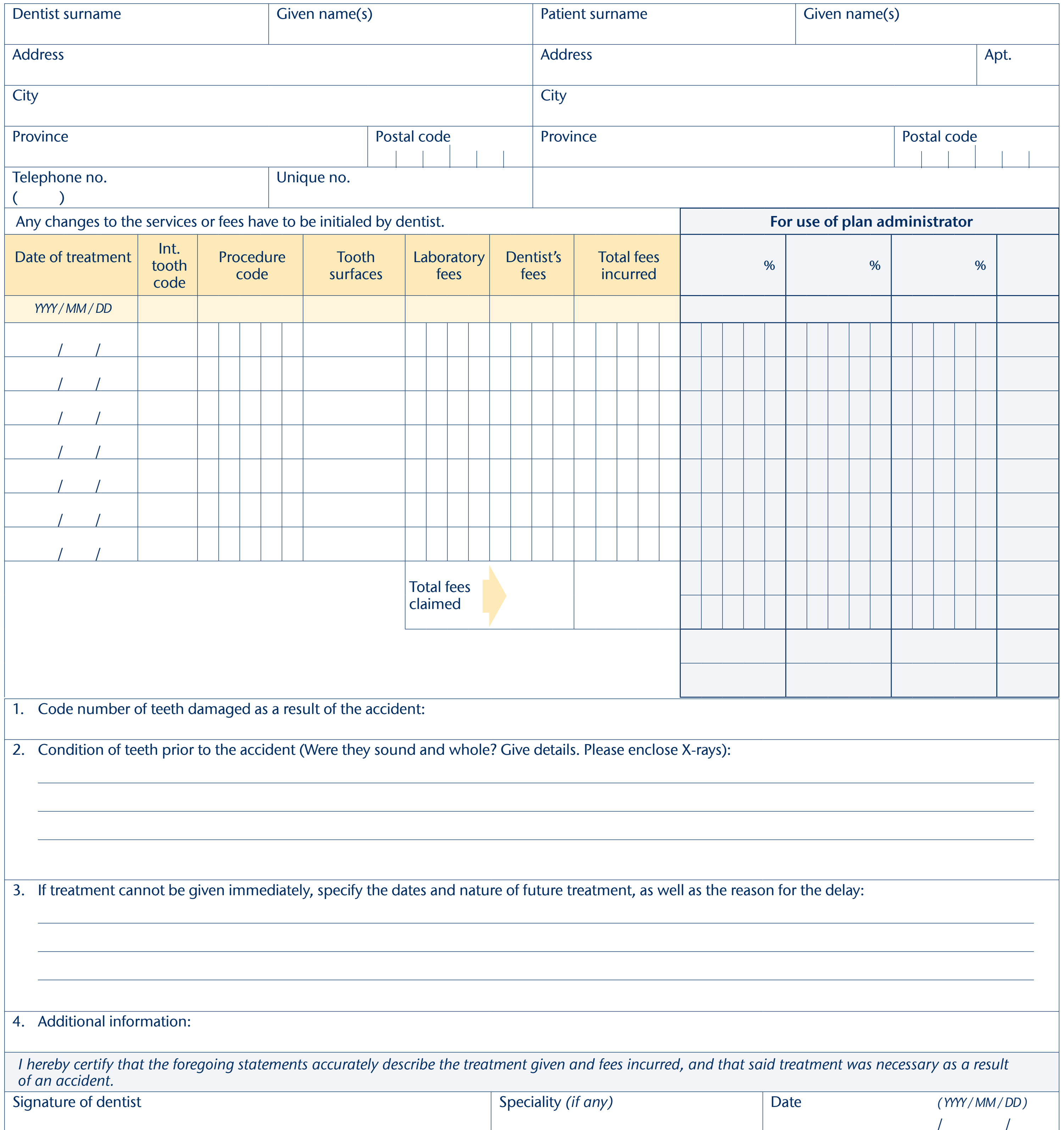
I certify that the information contained in this form is true, correct and complete and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life will automatically reject this claim in all or in part.

A photocopy of this authorization is valid as the original.

Participant signature	Date *(YYYY / MM / DD)* / /
Injured person signature	Date *(YYYY / MM / DD)* / /

Have your dentist complete the reverse side.

Dentist statement



Dentist surname	Given name(s)	Patient surname	Given name(s)
Address		Address	Apt.
City		City	
Province	Postal code	Province	Postal code
Telephone no. ( )	Unique no.		

Any changes to the services or fees have to be initialed by dentist.

Date of treatment	Int. tooth code	Procedure code	Tooth surfaces	Laboratory fees	Dentist's fees	Total fees incurred	For use of plan administrator %	%	%	
YYYY / MM / DD										
/ /										
/ /										
/ /										
/ /										
/ /										
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/ /										
				Total fees claimed						

1. Code number of teeth damaged as a result of the accident:

2. Condition of teeth prior to the accident (Were they sound and whole? Give details. Please enclose X-rays):

3. If treatment cannot be given immediately, specify the dates and nature of future treatment, as well as the reason for the delay:

4. Additional information:

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that said treatment was necessary as a result of an accident.

Signature of dentist	Speciality *(if any)*	Date *(YYYY / MM / DD)* / /