Chambers of Commerce
Group Insurance Plan®

Please print your Firm & Certificate #

Firm #	Certificate #

D E N T A L C L A I M

Instructions: 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**

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

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan.

I certify that the answers to the above questions are full and true to the best of my knowledge and represent 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 understand that the fees listed in this claim may not be covered or may exceed my group insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges. I authorize Chambers Plan, its advisors and service providers, any health care provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Chambers Plan and its insurance companies to exchange information when necessary to assess my claim and to administer the group benefit plan.

A photocopy of this authorization is as valid as the original when obtaining information.

Employee's Signature _____ Date _____

Insuring Company: Desjardins Financial Security