CAE

Sun Life Financial

Dental Claim Form

Approved by the Canadian Dental Association

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Dentist

PATIENT

Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

Unique Number | 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 ☐

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 in this claim form to my insuring company / plan administrator.

Signature of Patient (Parent/Guardian)

Office Verification/Dentist's Signature

Date of Service Day	Month	Year	Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable E & OE

TOTAL FEE SUBMITTED

For Plan Administrator Use Only

2 To be completed by Member

You must complete this section.

Member Information

Contract Number **25289**

0 ☐ division | 0 0 0 | ☐☐☐☐☐ employee No.

salaried=2 unionized=3

Date of Birth Day / Month / Year

Last Name | Given Name | ☐ Male ☐ Female

Street Address | Daytime Tel. No. ( )

City | Province | Postal Code | Evening Tel. No. ( )

3 Spouse and Children Covered by this Claim

Complete only if claim is for your spouse or child.

Spouse's Full Name | ☐ Male ☐ Female | Date of Birth Day / Month / Year

Child's Name	Relationship to you Son	Daughter	Date of Birth Day	Month	Year	Complete for overage dependents (refer to benefit information for age limits) Disabled	Full-time Student
	☐	☐				☐	☐

continued on reverse side

4 Co - ordination of Benefits

Indicate if your Spouse and/or children has coverage under any other dental plan or contract.

Is your spouse and/ or children covered for any of these expenses under any other dental plan or contract?

No ☐ Yes ☐ Spouse's date of birth: ___/___/___ (Day Month Year)

If yes:
- You must submit a claim for your spouse to his/her plan **first.**
- You must submit a claim for your child **first** under the plan of the parent with the earliest birthday (month and day) in the calendar year.

If your spouse's plan is also with us: Contract Number: _____ Member ID: _____

Do you want us to co-ordinate benefits (process both claims)? No ☐ Yes ☐

If yes, Spouse's Signature: _____ Date: ___/___/___ (Day Month Year)

5 Details of Claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

1. Are any expenses the result of an accident? No ☐ Yes ☐ If yes, complete the following:

When and where did the accident occur? Day / Month / Year Work ☐ Home ☐ Other ☐

How did the accident occur?

Are any expenses the result of a condition covered by a workers' compensation program ? No ☐ Yes ☐

2. Is this treatment for: orthodontic purposes? No ☐ Yes ☐ Implants? No ☐ Yes ☐

3. Crowns, Bridges, Dentures — Is this the initial placement? No ☐ Yes ☐

If No,
- Date of prior placement: ___/___/___ (Day Month Year)
- Reason for replacement: _____

If Yes,
- Date teeth were extracted (for denture or bridge): ___/___/___ (Day Month Year)

Please include the following to facilitate handling of your claim:
- Pre-treatment x-rays (for crowns , bridges, veneer, inlays, onlays)
- List of all missing teeth (for bridges only)

6 Authorization and Signature

You must complete this section.

Fraudulent claims are very costly for all participants in benefit plans. As administrator of this plan, we may check the accuracy of the information given in support of your claim.

I certify that all goods or services being claimed have been received by me/my dependents. 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 certify that the information in this form is true and complete and does not contain a claim for any expenses previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event that this Plan is audited.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member Signature _____ Date Day / Month / Year

For details specific to your plan, consult your benefit information package or visit our web site, **www.sunlife.ca**

Mail the completed form to the nearest **Sun Life Assurance Company of Canada Health Claims Office:**

EASTERN REGION
Atlantic Canada, Quebec and Eastern Ontario
PO Box 6076 Stn CV
Montreal QC H3C 4S3

CENTRAL REGION
Ontario (except Eastern Ontario)
PO Box 4023 Stn A
Toronto ON M5W 2P7

WESTERN REGION
Western Canada, N.W.T. and Yukon
PO Box 2880 Stn Main
Edmonton AB T5J 4S6

For more information call 1-800-361-6212

Please retain a copy of your claim form and receipts for your records.