Chambers Plan
Employee Benefits

J G 1 6 - C H

Dental Accident Claim

Please print your Firm & Certificate #

Firm #	Certificate #

The Dentist completes parts 1 and 2. The Employee completes part 3. Please ensure all questions on the reverse side are answered or your claim may take longer to process.

PART 1. DENTIST

DENTIST

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

Phone Number

PATIENT

Patient's Name _____

Home Address _____

City _____

Province _____ Postal Code _____

DATE OF SERVICE YYYY MM DD	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 _____

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of damage _____

2. Is further treatment indicated? ❑ No ❑ Yes If Yes, please describe.

INT. TOOTH CODE	TREATMENT INDICATED – USE PROCEDURE CODE IF POSSIBLE	ESTIMATED DATE OF TREATMENT YYYY	MM	DD

3. Describe further potential problems and indicate time frame _____

Dentist's Signature _____ Date _____

CONTINUED

Chambers Plan
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Dental Accident Claim (continued)

PART 3. EMPLOYEE'S STATEMENT

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

   _____ Employee's birthdate (YYYY/MM/DD) _____
3. Patient's relationship to Employee _____ Patient's birthdate (YYYY/MM/DD) _____
4. If your firm has a **Health Spending Account**, please apply the balance of this claim towards this benefit. ❑ No ❑ Yes
5. 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 (YYYY/MM/DD) _____
6. Are any of the services provided as a result of an accident? ❑ No ❑ Yes

   If "Yes," provide the date and details of the accident. _____
7. Are you claiming for a dependent child who is age 21 or older? ❑ No ❑ Yes
   If the patient is a dependent child, the child: ❑ has a physical or mental disability
   ❑ is a student (school's name and location) _____

   _____ Dates of studies (YYYY/MM/DD) _____
8. 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. _____
9. Is any treatment required for orthodontic purposes? ❑ No ❑ Yes
10. Please provide date of accident _____ 20_____ at _____ a.m./p.m.
11. Location of accident _____
12. Was the accident work related? ❑ No ❑ Yes
13. Date of first treatment (YYYY/MM/DD) _____
14. Please provide details of accident _____

    _____

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.

If this claim includes an amount under my Health Spending Account, I certify that the amount qualifies as a medical expense for income tax purposes. I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

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 _____

ALL THE INFORMATION YOU PROVIDE ON THIS FORM WILL BE TREATED AS CONFIDENTIAL.

Please mail this completed form and your original receipts to
Chambers of Commerce Group Insurance Plan, 1051 King Edward Street, Winnipeg, MB R3H 0R4
Telephone 1-800-665-3365 • Fax 1-800-457-8410

Insuring Company: Desjardins Insurance
Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company

THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM.