



DENTAL CLAIM FORM

PART 1 - TO BE COMPLETED BY PROVIDER				Licence No	Spec	Patient's Office Account No.	REMIT PAYMENT TO PROVIDER		
P A T I E N T	Patient Last Name	First Name		P R O V I D E R	Phone No	I hereby assign my benefits payable from this claim to the named provider and authorized payment directly to him/her _____ Signature of Participant			
	Address	Apt.							
	City	Province	Postal Code						
For provider's use only - for additional information, diagnosis, procedures, or special consideration.				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 provider for the entire treatment. I also authorize the communication of information related to the coverage of services described in this form to the named provider. Signature of Patient (Parent/Guardian) _____					
Date of Service YYYY MM DD	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charges	Total Charges	Allowed Amount	Code	
This is an accurate statement of services performed and the total fee due and payable.				TOTAL FEE SUBMITTED					
				Provider Signature : _____			Date : _____		

INSTRUCTIONS FOR CLAIM SUBMISSION:

Please carefully fill in all pertinent areas and sign the completed form. (Refer to SSQ Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - PARTICIPANT		All claims must be submitted within 12 months of the date of service.	
Participant's Name (Please Print)		SSQ Certificate Number	Participant's Date of Birth
		-00	YYYY MM DD
Last Name	First Name		

PART 3 - PATIENT INFORMATION			
Patient's Name (Please print)		Sex	Female <input type="checkbox"/>
			Male <input type="checkbox"/>
		Patient's Date of Birth	
		YYYY MM DD	
Last Name		First Name	
1. Patient: Relationship to Participant _____			
If child, indicate: Student <input type="checkbox"/> Handicapped <input type="checkbox"/>			
If student, indicate school _____			
2. Are any dental benefits or services provided under any other group insurance, dental plan, or Government Plan?			
No <input type="checkbox"/> Yes <input type="checkbox"/>			
Name of other insuring Agency or Plan _____			
If Yes, Policy No. _____ Spouse Date of Birth _____			
3. Is any treatment required as the result of an accident? If Yes, please complete the Dental Accident Report form. No <input type="checkbox"/> Yes <input type="checkbox"/>			
4. If denture, crown or bridge, is this initial placement? No <input type="checkbox"/> Yes <input type="checkbox"/> Give date of prior placement and reason for replacement. Date: ____/____/____			
5. Is any treatment required for orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>			
I authorize the release of any information or records required in respect of this claim to insurer /plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.			
Signature of Participant			Date
			YYYY MM DD
All information recorded on this form is confidential.			

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ Insurance about myself and my dependents, will be used by SSQ Insurance for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

SSQ Life Insurance Company Inc. is committed to keeping your information confidential.