SASKATCHEWAN PIPING INDUSTRY HEALTH & WELFARE

STANDARD DENTAL CLAIM FORM

Agent/ Administrator **Global Benefits**
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CANADIAN DENTAL ASSOCIATION

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THE CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT: LAST NAME GIVEN NAME
ADDRESS APT.
CITY PROV. POSTAL CODE

DENTIST: PHONE NO.

FOR DENTIST'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 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 CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGES	TOTAL CHARGES

FOR CARRIER USE

ELIGIBLE
TERM/O.O.B.
REINSTATED

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1. 2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.

PART 2 — MEMBER

SASKATCHEWAN

1. CONTROL NO/PLAN NO. BRANCH NO.
PRESENT EMPLOYER
2. NAME OF MEMBER
ADDRESS OF MEMBER

☐ INITIAL CLAIM? SUBSEQUENT? ☐
TELEPHONE NUMBER: HOME BUS.
MEMBER'S DATE OF BIRTH: DAY MONTH YEAR
MEMBER'S SOCIAL INSURANCE NUMBER

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE
DATE OF BIRTH: DAY MONTH YEAR
PATIENT'S OCCUPATION
2. IF CLAIM IS FOR THE DEPENDENT CHILD, IS THAT CHILD
HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐
A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐
ARE YOU ENTITLED TO AN INCOME TAX EXEMPTION FOR THIS DEPENDENT? ☐ YES NO ☐
NAME AND ADDRESS OF DEPENDENT'S EMPLOYER
3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES? ☐ YES NO ☐ IF "YES", PROVIDE:
POLICY NUMBER:
NAME OF INSURER:
SPOUSE'S NAME:
SPOUSE'S DATE OF BIRTH: DAY MONTH

4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐
5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐
GIVE DATE AND DETAILS
B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐
6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
A) IS THIS THE INITIAL PLACEMENT?
UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐
B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT
C) DATE OF EXTRACTIONS

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date ____ / ____ / ____ Signature of Member Telephone Number ( )

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL