INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

www.inalco.com

GROUP INSURANCE

# CLAIM FORM
# DENTAL CARE

According to your region, please submit the completed form to:

**Quebec**
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

**Ontario, Atlantic and Western Provinces**
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

## PART 1: DENTIST'S STATEMENT

Patient (Last and first name)

Dentist (Last and first name / Address / 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 to provide additional information, diagnosis, procedures, or special considerations:

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered.

Duplicate ❑ Predetermination ❑

Member's signature _____

Verification (Dentist) _____

### Treatment and services rendered to the patient

| Date of service Y | M | D | Procedure code | Internal tooth code | Tooth surfaces | Dentist's fees | Laboratory charges | Total charges |
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Excluding any possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

**Total fee submitted**

## PART 2: MEMBER'S STATEMENT

Policy no. | | | | | | Policyholder's name _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth Y M D Sex: ❑ M ❑ F Language: ❑ E ❑ F

### COORDINATION OF BENEFITS

***IMPORTANT NOTE:***

*Under the coordination of benefits section of your plan, if your spouse is covered under a dental care benefit, the expenses incurred by your spouse must first be submitted to his/her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.*

*The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.*

**Is your spouse, if applicable, covered by another group plan? ❑ No ❑ Yes Specify:**

Name of insurance company _____ Policy no. _____ Coverage: ❑ Individual ❑ Family

Name of spouse _____ Date of birth Y M D

**PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.**

**1.** If expenses are incurred for a dependent, specify:

Last name _____ First name _____

Relationship to member _____ Date of birth Y M D

Children 18 and over: ❑ Handicapped ❑ Full-time student Name of school _____

**2.** If the claim is the result of an accident, specify: ❑ Work ❑ Motor vehicle ❑ Other
and complete the "Dental Care in Case of an Accident" form (F54-267A)

**3.** Is any treatment planned for orthodontic purposes? ❑ Yes ❑ No

**4.** For a denture, crown or bridge, is this an initial placement? ❑ Yes ❑ No IF YES, please submit pre-treatment x-rays.

IF NO, specify date of prior placement Y M D and the necessity for replacement: _____

_____

_____

**5.** For a fixed bridge, have you or do you currently wear a partial denture? ❑ Yes ❑ No

IF YES, specify date of last placement Y M D and the necessity for replacement: _____

_____

## MEMBER CONFIRMATION/AUTHORIZATION

**I HEREBY CONFIRM** that the information contained in this claim form is true and complete to the best of my knowledge.

If this claim is being made on behalf of my spouse and or/dependent children, **I CONFIRM that I am AUTHORIZED** to disclose information about them with respect to this claim.

On behalf of myself and my dependents:

**(1) I consent to the RELEASE** of the information contained in this claim form to Industrial Alliance, its employees, agents, reinsurers and service providers for the purposes of underwriting, administration and processing of the claim; and

**(2) I AUTHORIZE** any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution to disclose to Industrial Alliance, its employees, agents and service providers any information regarding the treatment charges incurred which they may need in the assessment of the claim.

**I AUTHORIZE** the use of my Social Insurance Number as an identification number where it is required for the administration of the group policy.

**I AGREE** that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Member's signature **X** _____ Date _____

Address _____ Postal code

Tel. home Tel. work

## DISCLOSURE

At Industrial Alliance, the personal information we collect concerning you and your insured dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following address: Industrial Alliance Insurance and Financial Services Inc., Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.

Industrial Alliance may establish a list of its insureds to share information within the Industrial Alliance Group. This will help us serve them better and determine whether any products and services that the Industrial Alliance Group offers are suitable so we can offer such products and services to them. However, you are entitled to have your name removed from this list by making a written request to this effect to the Access Officer, as referred to above.