



Dental Claim									Plea	ase	prin	nt you	ur Firm & Certificate #			ificate#	Firm# Certificate#				
PART 1. DENTIST Unique # Spec.							Patient's Office Account #							ı							
																Patient's Name					
D E										- 1	A T I										
N	i														1						
ı														- 1	NI.	-					
S	P	hone Nu	mber											- 1	T I	Provi	nce			Postal Code	
DΔ	TF OF	SERVICE	l <sub>pp</sub>	OCEI	OURE	I INTL.	ı	тоотн	L	DENTI	2,12	ا ا	∆R∩I	ΡΔΤί	ORY	l	T01	ΓΔΙ	ı	FOR DENTIST'S USE, FOR ADDITIONAL INFORMATION, DIAGNOS	ıs
	DAY MO.			CODE		INTL. TOOTH CODE	_	SURFACES		FEE			CHA				CHARGES			PROCEDURES, OR SPECIAL CONSIDERATION	
_			Н		+		+		+			+		+					+-		
			П				+		T					$\dagger$							
			П											$\Box$							
		_	Н	+	-		+		$\perp$	_		+		$\dashv$		H			+-		
			Н	+			+		+			+		+		$\vdash$			+-		
			Н				+		$\dagger \dagger$					+		$\vdash$			$\Box$	OPTIONAL ASSIGNMENT OF BENEFITS	5
																				I hereby assign my benefits payable from this claim	
									T(	DTAL	. FEE	SUBM	IITT	ED	)					authorize payment directly to the named Dentist.	
						performed accepted. <b>D</b> o		al fee gnature												Employee's	
PA	RT 2.	EMPL	OYE	E'S :	STATE	MENT													'	Signature	
1.	Nam	ne of Ei	nplo	yer																	
2.	Nam	ne and a	ddre	SS C	f Emp	oyee															
		Employee's birthdate (YYYY/MM/DD)																			
3.	Patie	atient's relationship to Employee Patient's birthdate (YYYY/MM/DD)																			
4.	If yo	your firm has a Health Spending Account, please apply the balance of this claim towards this benefit. 🔲 No 🚨 Yes																			
5.	Are y	you or y	our/	dep	endent	s entitle	d to ben	efits under any oth	ner p	lan?		No 🗆	Y	es	If "Y	'es," f	ami	-		insured	
														—				_ Sp	oouse's	birthdate (YYYY/MM/DD)	
6.								of an accident?													
7								accident.													
/.		Are you claiming for a dependent child who is age 21 or older? □ No □ Yes fthe patient is a dependent child, the child: □ has a physical or mental disability																			
		o patioi			p 0a.o.									ion)	ı)						
																				Dates of studies (YYYY/MM/DD)	
8.		If treatment is a denture, crown or bridge, is it an initial placement?																			
								•													
		•						urposes? $\square$ No													
																				claim for services rendered to me and/or eligible memb out them for the purposes of assessing and paying a be	
for	whon	n I am n	nakir	ga	claim a	re eligibl	e and in		ouse	and	any	depend	den	ts a	as defi	ined ι				nse for income tax purposes. I also acknowledge that t th Spending Account coverage. I understand that shoul	
ass me	essme dical a	ent, inve and hea	estiga Ith p	ntior rofe:	ı, claim ssional	manage s, facilitie	ment, ui s or pro	nderwriting and for viders, insurance co	dete mpa	rmini nies,	ing P or ot	lan elig her org	gibil gan	lity. izati	The ntions/p	non-e perso	xhau ons. <sup>-</sup>	usti This	ive list of s authori	vant to this claim for the purposes of benefit plan admin of sources from which information can be collected incluization is also valid for the collection, use and commun	udes iication of
per	sonal	intorma	ition	con	cerning	g my dep	endents	, insotar as applicat	ole to	the a	admi	nistrati	ion	of b	benefi	ts un	der 1	this	s plan. A	photocopy of this authorization is as valid as the origin	ıal.
Sig	ignature of Employee												Date								





## **Dental Claim**

## **INSTRUCTIONS (Please read carefully)**

The Dentist completes part 1. The Employee completes part 2. Please ensure all questions are answered or your claim may take longer to process. Send completed claim form to:

> **Chambers of Commerce Group Insurance Plan** 1051 King Edward Street Winnipeg, MB R3H OR4 Telephone 1-800-665-3365 • Fax 1-800-457-8410



## WANT TO GET YOUR CLAIM PAID FASTER?

## **SUBMIT YOUR CLAIMS ONLINE**

- Go to www.my-benefits.ca and register for the Plan member secure site
- Sign up for DIRECT DEPOSIT
- Submit claims online and SAVE TIME, PAPER AND MONEY!
- Download our app from either Google Play or the Apple Store.



