



DENTAL CARE INSURANCE BENEFIT CLAIM

Policy Number: 32S20

Effective October 1, 2008, all medical, dental and life insurance claims should be submitted to:

CEP 24/7 Benefit Trust

c/o Global Benefits Claims Department

545 Wilson Avenue

Toronto ON M3H 1V2

Patient				Dentist			
Last Name: _____				Name: _____			
First Name: _____				Address: _____			
Address: _____		Apt.: _____		Town/City: _____		Province: _____	
Town/City: _____		Province: _____		Postal Code: _____		Telephone: _____	
Postal Code: _____		Telephone: _____		Unique No.: _____			

DATE OF SERVICE			INT'L TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL FEES CLAIMED	FOR SSQ USE ONLY	
Y	M	D								

THIS IS AN ACCURATE DESCRIPTION OF THE TREATMENT PROVIDED AT THE DATE OF SERVICE INDICATED (OR TO BE PROVIDED IN THE CASE OF A TREATMENT PLAN) AND OF THE CORRESPONDING FEES CHARGED AND PAID.

	TOTAL FEES CHARGED: ▶	
	TOTAL FEES PAID BY THE PATIENT: ▶	

DATE
Y M D

DENTIST'S SIGNATURE _____

FOR DENTIST'S USE ONLY TO INCLUDE ADDITIONAL INFORMATION (USE BACK OF FORM IF NECESSARY).

COMPLETED BY: _____	DATE: _____
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A) TO BE COMPLETED BY THE PARTICIPANT

1. a) PATIENT'S RELATIONSHIP TO PARTICIPANT: _____

PATIENT'S DATE OF BIRTH
Y M D

b) FOR AN OVERAGE DEPENDENT, INDICATE IF UNMARRIED AND A FULL-TIME STUDENT: NO YES

c) NAME OF SCHOOL: _____

2. a) IS THIS TREATMENT COVERED UNDER ANY OTHER INSURANCE PLAN? NO YES

b) IF «YES», NAME OF THE COMPANY AND POLICY NUMBER: _____

3. IS THIS TREATMENT REQUIRED DUE TO AN ACCIDENT? NO YES

IF «YES», COMPLETE BACK OF FORM

4. IF CLAIM IS FOR DENTURES, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT? NO YES

IF «NO», GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT:
Y M D

CONTRACT NO. _____ Social Insurance Number _____

PARTICIPANT'S LAST NAME _____

PARTICIPANT'S FIRST NAME(S) _____

ADDRESS _____

POSTAL CODE _____

I UNDERSTAND THAT THE FEES INDICATED IN THIS CLAIM MAY NOT BE COVERED BY, OR MAY EXCEED, MY PLAN BENEFITS. I ACKNOWLEDGE THAT THE TOTAL FEES AND THE DATES OF SERVICE INDICATED IN THIS FORM ARE ACCURATE AND THAT I WAS CHARGED FOR AND HAVE PAID THE TOTAL FEES SPECIFIED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURER, SSQ LIFE INSURANCE COMPANY INC., AND ITS AGENTS. I ALSO AUTHORIZE MY INSURER, SSQ LIFE INSURANCE COMPANY INC., AND ITS AGENTS, TO DISCLOSE ANY INFORMATION CONTAINED IN THIS FORM AS REQUIRED FOR THE EXAMINATION AND ADMINISTRATION OF THIS CLAIM.

Y M D

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN) _____ DATE _____

I CERTIFY THAT THIS INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Y M D

PARTICIPANT'S SIGNATURE _____ DATE _____

