UA LOCAL 787 HEALTH PLAN

DENTAL CLAIM FORM

PART 1 DENTIST

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

PATIENT: LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST: PHONE NO.

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

SIGNATURE OF SUBSCRIBER

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 FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT / GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DUPLICATE FORM ☐

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

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. EMPLOYEE COMPLETES PART 2 AND PART 3.
2. HAVE YOUR DENTIST COMPLETE PART 1.
3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
4. SEND THIS CLAIM TO:
   ADMINISTRATION OFFICE
   45 McINTOSH DRIVE, MARKHAM, ONTARIO L3R 8C7
   TELEPHONE: (905) 946-9700 FAX: (905) 946-2535
   CANADA TOLL FREE: 1-800-263-3564

Or Submit Claim Directly - Your Dentist

can do this using the All In One Benefit Card

PART 2 MEMBER IDENTIFICATION

MEMBER'S NAME _____ UNION IDENTIFICATION NUMBER _____

MOST RECENT EMPLOYER _____ DATE OF BIRTH _____/_____/_____ (DAY / MONTH / YEAR)

AUTHORIZATION AND SIGNATURE:

I certify that, if this claim is being made on behalf of my Spouse and/or Dependants, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I certify that the information given is true, correct and complete to the best of my knowledge. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

Please complete all of the above information. The claim will be returned if any information is missing. **SIGNATURE** _____

PART 3 MEMBER'S STATEMENT (please print)

1. PATIENT'S RELATIONSHIP TO MEMBER _____ 2. PATIENT'S DATE OF BIRTH _____/_____/_____ (DAY / MONTH / YEAR)
3. IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU? YES ☐ NO ☐
4. IF THE PATIENT IS A CHILD 21 YEARS OR OLDER:
   A) IS HE / SHE A FULL-TIME STUDENT? YES ☐ NO ☐ IF YES, NAME OF SCHOOL _____
   B) IS HE / SHE EMPLOYED? YES ☐ NO ☐ IF YES, HOW MANY HOURS WORKED PER WEEK? _____
5. A) ARE YOU OR ANY MEMBER OF YOUR FAMILY ENTITLED TO DENTAL BENEFITS FROM ANY OTHER PLAN? YES ☐ NO ☐
   IF YES, GIVE NAME AND ADDRESS OF OTHER PLAN
   _____
   NAME OF FAMILY MEMBER INSURED _____ POLICY # _____
   B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? YES ☐ NO ☐
   IF YES, NAME OF FAMILY MEMBER
   _____
   C) IF YES TO A) OR B) ABOVE, AND THE PATIENT IS A DEPENDANT CHILD, PLEASE PROVIDE SPOUSE'S BIRTH DAY AND MONTH _____/_____ (DAY / MONTH)
6. IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ NO ☐ IF YES, GIVE DATE, LOCATION AND EXPLAIN HOW ACCIDENT HAPPENED
   _____
7. IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
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