The Maritime Life Assurance Company

Dental Expense Claim

CANADIAN DENTAL ASSOCIATION

CANADIAN LIFE AND HEALTH INSURANCE ASSOCIATION INC.

PART 1 DENTIST

UNIQUE NO | SPEC | PATIENT'S OFFICE ACCOUNT NO

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO SAME

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV POSTAL CODE

DENTIST

PHONE NO

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 CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

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 THIS TOTAL FEE DUE AND PAYABLE E & OE

TOTAL FEE SUBMITTED

- For Plan Administrator Use Only -

Member's Insured Date ____ / ____ / ____ (Day / Month / Year)

Member's Termination Date (if applicable) ____ / ____ / ____ (Day / Month / Year)

Was Member in Benefit when expenses were incurred? ☐YES ☐NO

IN BENEFIT HISTORY

Year	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec

Signature Verifying Eligibility Date

PART 2 MEMBER — COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

GROUP POLICY No. _____ **Name of Union** _____ **Local** _____

1. Member's Name _____ (First / Initial / Last) Social Insurance No. ☐☐☐☐☐☐☐☐☐
2. Member's Date of Birth ____ / ____ / ____ (Day / Month / Year) Employee/Certificate No. (If applicable) _____
3. Is this your first claim with Maritime Life? ☐NO ☐YES
4. Address _____ (Street / City/Town / Province / Postal Code)
5. Are dental benefits payable for this claim from any other company or source? ☐ NO ☐ YES
   If 'Yes' name company or source _____
6. a) If denture, bridge or crown, is this an initial placement? ☐NO ☐YES
   b) If initial placement, please advise date teeth were extracted and all other missing teeth in arch: _____
   c) If replacement, give date of prior placement and reason for replacement: _____
7. Which family member are these expenses being claimed for? _____ (Name) Is this family member the (check one) ☐ Employee ☐ Spouse ☐ Son ☐ Daughter

If this family member is a spouse or child, complete the following information:

8. Dependent's Date of Birth ____ / ____ / ____ (Day / Month / Year) 9. Is this dependent working? NO ☐ YES ☐ Is this dependent attending school? NO ☐ YES ☐
   If 'YES' give name of employer or school _____
10. If treatment is due to an accident, indicate date of accident and details _____

I authorize Maritime Life and/or its authorized representative to collect, use and disclose personal information concerning me and/or my dependent(s) (where applicable) for the purpose of determining eligibility for Maritime Life products and services; underwriting and administration of coverage: the adjudication and payment of claims and other relevant purposes, all of which are described in more detail in Maritime Life's Privacy Policy and Privacy Information Package, available at www.maritimelife.ca or by request.

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.

Signature of Plan Member (in full) Date