MUTUAL

DENTAL CLAIM AND TREATMENT PLAN FORM

GROUP INSURANCE

DENTIST			PATIENT	
NAME	SURNAME		NAME	SURNAME
ADDRESS			ADDRESS	
CITY	PROVINCE	POSTAL CODE	CITY	
TELEPHONE	**PERMIT NUMBER**		PROVINCE	POSTAL CODE

TREATMENT YEAR	MTh	DAY	INTERNAT. CODE TOOTH		PROCEDURE CODE	SURFACE OR SEXTANT	LABORATORY CHARGE	DENTIST'S FEE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED, OR OF SERVICES TO BE PERFORMED AND FEES TO BE CHARGED IN THE CASE OF A TREATMENT PLAN, EXCEPT ERRORS AND OMISSIONS.

X

SIGNATURE OF DENTIST

TOTAL FEES SUBMITTED

DATE ▸ YEAR / MONTH / DAY

☐ **DUPLICATE FORM**

SECTION RESERVED FOR INSURER

ADMISSIBLE FEES	MOTIVE (*)	% REIMBURSEMENT %	B %	C/D %	TOTAL AMOUNT

TOTAL ▸

SECTION RESERVED FOR THE DENTIST FOR ADDITIONAL INFORMATION ON THE DIAGNOSIS, COMPLICATIONS OR SPECIAL TREATMENTS.

_____

_____

☐ **TREATMENT PLAN**

THIS ESTIMATE IS VALID FOR 60 DAYS ONLY. FEES DO NOT COVER COMPLICATIONS THAT MAY OCCUR DURING AND AFTER TREATMENT. LABORATORY COSTS ARE APPROXIMATE.

NO DATE OF TREATMENT SHOULD APPEAR ON THIS FORM.

I UNDERSTAND THAT THE FEES LISTED ON THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY BENEFITS PLAN
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED ON THIS FORM TO MY INSURANCE COMPANY OR PLAN ADMINISTRATOR.

X

*** MOTIVE CODES:** _____

1. ELIGILE EXPENSES ARE THOSE WHICH DO NOT EXCESS SUGGESTED FEES FOR GENERAL PRACTITIONERS IN THE QUEBEC DENTAL FEE GUIDE.
EDITION _____

2. THE MAXIMUM PAYABLE PER YEAR IS _____ $

3. THIS TREATMENT IS NOT COVERED ACCORDING TO THE DENTAL INSURANCE PLAN.

4. THE ANNUAL MAXIMUM AMOUNT OF _____ $
HAS BEEN PAID FOR THE YEAR _____.

5. PAYMENT FOR THIS TREATMENT IS ELIGIBLE ONCE EVERY _____ MONTHS.

6. SEE ENCLOSED LETTER.

7. OTHERS: _____

SECTION TO BE COMPLETED BY INSURED

1. NAME OF INSURED _____

2. IF IT IS A CLAIM FOR A DEPENDANT PERSON, INDICATE RELATIONSHIP TO INSURED :
☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY) _____
DATE OF BIRTH, DEPENDANT PERSON: YEAR _____ MONTH _____ DAY _____
IF DEPENDANT CHILD IS AGED OVER 17 YEARS, INDICATE NAME OF SCHOOL ATTENDED, IF APPLICABLE:
_____

3. IF DENTURE, CROWN OR BRIDGE, IS THIS THE INITIAL PLACEMENT? **YES ☐ NO ☐**
IF NO, INDICATE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT:
_____

4. IF THE TREATMENT REQUIRED IS A RESULT OF AN ACCIDENT, INDICATE THE DATE AND THE NATURE OF THE ACCIDENT :
_____

5. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN?
YES ☐ NO ☐ IF YES, INDICATE THE POLICY NUMER AND THE NAME OF THE INSURING AGENCY:
_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

X

DATE **SIGNATURE OF INSURED**

SECTION TO BE COMPLETED BY POLICYHOLDER

1. NAME OF EMPLOYER / ASSOCIATION :
_____
_____
_____

2. CONTRACT NUMBER (GROUP) : _____
DIVISION : _____

3. POLICYHOLDER'S CERTIFICATE NUMBER:
_____

4. IS THE INSURED STILL EMPLOYED BY YOUR SERVICE:

YES ☐ NO ☐
IF NO, SINCE WHAT DATE DID EMPLOYMENT TERMINATE:
YEAR _____ MONTH _____ DAY _____

X

DATE **AUTHORIZED SIGNATURE**

RETURN TO THE FOLLOWING ADDRESS :

THE UNION LIFE MUTUAL ASSURANCE COMPANY
142, HERIOT, P.O. BOX 696
DRUMMONDVILLE (QUEBEC) J2B 6W9