Equitable Life of Canada®

Head Office
Group Dental Claims Department
One Westmount Road North
P.O. Box 1605 Stn. Waterloo, Waterloo Ontario N2J 0A8
TF 1.800.265.4556 **T** 519.886.5210 **Fax** 1.888.505.4373
Email group-dental-claims@equitable.ca

DENTAL CLAIM FORM

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 HIM/HER.

PATIENT
LAST NAME | GIVEN NAMES
ADDRESS | APT.
CITY | PROVINCE
POSTAL CODE

DENTIST
NAME
ADDRESS
POSTAL CODE
TELEPHONE NO.

SIGNATURE OF SUBSCRIBER (INSURED)

FOR DENTIST USE ONLY — FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED 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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

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

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

TOTAL FEE SUBMITTED $

Falsifying or tampering with claim documents / receipts could have legal consequences.

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE YOUR DENTIST COMPLETE PART 1, 2 AND 3.
2. AFTER PART 1 IS COMPLETE, SIGN PART 1 ACKNOWLEDGING DENTIST'S FEE.
3. ENSURE COMPLETION OF PART 2 AND 3 IN FULL. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR CLAIM.

PART 2 EMPLOYER/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO: 812425 DIVISION NO: _____

EMPLOYER: IBEW Local 258 Electrical Workers Health & Welfare Trust

2. INSURED'S NAME (PLEASE PRINT): _____

DATE OF BIRTH: (Day_____Month_____Year _____) INSURED'S CERTIFICATE/I.D. NO: _____

IF YOU HAVE A HEALTH CARE SPENDING ACCOUNT (HCSA) PLEASE COMPLETE THE FOLLOWING.

TO ENSURE YOU MAXIMIZE YOUR BENEFIT COVERAGE, REVIEW ANY COVERAGE YOU HAVE THROUGH ANY PROVINCIAL HEALTH INSURANCE OR PRIVATE PLAN AND CLAIM ACCORDINGLY. A PRIVATE PLAN MAY INCLUDE BENEFIT COVERAGE YOU AND/OR YOUR DEPENDENTS HAVE THROUGH ANOTHER INSURANCE CARRIER. YOU MAY FIND IT USEFUL TO REVIEW THE COORDINATION OF BENEFITS PROVISIONS IN YOUR PLAN MEMBER BOOKLET/BROCHURE.

PLEASE COMPLETE NEXT PAGE

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DENTAL CLAIM FORM

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ I WANT MY ELIGIBLE EXPENSES PAID FROM MY EQUITABLE LIFE HEALTH OR DENTAL PLAN ONLY.

☐ I WANT MY ELIGIBLE EXPENSES PAID FROM MY EQUITABLE LIFE HEALTH OR DENTAL PLAN FIRST AND MY UNPAID PORTIONS OF MY ELIGIBLE EXPENSES PAID FROM MY HCSA.

☐ I WANT ALL MY ELIGIBLE EXPENSES PAID DIRECTLY FROM MY HCSA.

PLEASE NOTE: ***IF YOU DO NOT SELECT ANY OF THE ABOVE OPTIONS, NO PORTION OF THIS CLAIM WILL BE PAID FROM YOUR HEALTH CARE SPENDING ACCOUNT (HCSA)***

PART 3 PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER - _____ DATE OF BIRTH: (Day_____Month_____Year_____)

IF CHILD, INDICATE: ☐STUDENT ☐HANDICAPPED

IS HE/SHE ATTENDING SCHOOL FULL TIME? ☐NO ☐YES IF YES, INDICATE SCHOOL: _____

WHEN WILL HIS/HER SCHOOLING BE COMPLETED? (Day_____Month_____Year _____)

IS HE/SHE EMPLOYED FULL TIME? ☐NO ☐YES IS HE/SHE EMPLOYED PART TIME? ☐NO ☐YES HOW MANY PART TIME HOURS PER WEEK? _____

2. ARE DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN OR CONTRACT? ☐NO ☐YES IF YES, INDICATE THE FOLLOWING:
NAME OF OTHER INSURING AGENCY OR PLAN:_____ POLICY NO: _____
IF THIS PLAN IS ALSO WITH EQUITABLE LIFE®, PLEASE INDICATE MEMBER'S I.D.: _____
DO YOU WANT US TO CO-ORDINATE BENEFITS (PROCESS BOTH CLAIMS)? ☐NO ☐YES IF YES,
SPOUSE'S SIGNATURE: _____ DATE: (Day_____Month_____Year _____)

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐NO ☐YES IF YES, GIVE DATE AND DETAILS SEPARATELY.

A) ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN? ☐NO ☐YES
(ie. School Insurance, Workers' Compensation, etc.)

4. IS THIS CLAIM THE RESULT OF A MOTOR VEHICLE ACCIDENT? ☐NO ☐YES

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐NO ☐YES IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.

6. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐NO ☐YES

Authorization & Certification

I certify that the information given on this form is true, correct and complete to the best of my knowledge. The claim information willingly provided by me to Equitable Life held in their files, will be used by Equitable Life for the purposes of claims processing and adjudication. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, its sales distribution network, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to, pharmacies, physicians, dentists and any other person or party whom I authorize.

If applying for my spouse and/or dependents, I confirm that I am authorized to act on their behalf and therefore this consent and authorization also applies to the collection, use and communication of their personal information for the same purposes. I understand that claims made under the Group Insurance Policy are submitted through me as the plan member. I therefore authorize Equitable Life to exchange information about these claims with me or any person acting on my behalf, including a spouse or dependent, as deemed necessary for the purpose of confirming eligibility and assessing and managing the claim

If you are submitting your claim form electronically (visit www.equitablehealth.ca for more details)

☐ **Click to confirm and acknowledge your agreement with the above;**

OR

If you are printing your claim form to email, fax or mail it to Equitable Life, provide your written signature to confirm and acknowledge your agreement with the above:

Plan Member Signature _____ **Date** _____

Falsifying or tampering with claim documents / receipts could have legal consequences.

Claim Submission Instructions **Please keep a copy of your claim form and receipts for your own records.**

Electronic Submission - Visit www.equitablehealth.ca or www.equitable.ca and use our EZ Claim™ online feature to submit your Dental claim, along with your receipts and supporting documentation. This is a secure and confidential portal for claim submission.

Alternatively, you can scan and email your claim forms, with receipts as attachments, to group-dental-claims@equitable.ca or fax your documents to 519.883.7406 or toll free to 1.888.505.4373.

Please NOTE: While using the internet and email is convenient, sending confidential and personal information through the Internet is not secure. E-mail is vulnerable to interception. Equitable cannot ensure the privacy of information sent by email.

Mailing Instructions: Mail your completed and signed form to our Dental Claims department. Attach all receipts and supporting documentation. Please do not use staples.

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