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GROUP INSURANCE

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

**CLAIM FORM
DENTAL CARE – HSA**

Please print in ink and sign.

PART 1: DENTIST'S STATEMENT

Patient (Last and first name) _____ For dentist's use only to provide additional information, diagnosis, procedures, or special considerations: _____ Duplicate <input type="checkbox"/> Predetermination <input type="checkbox"/>	Dentist (Last and first name / Address / Phone no.) _____ _____ _____ _____ I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of subscriber I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered. Member's signature _____ Verification (Dentist) _____
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Treatment and services rendered to the patient

DATE OF SERVICE			PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEES	LABORATORY CHARGES	TOTAL CHARGES	HSA*
Y	M	D							
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>
								\$	<input type="checkbox"/>

Excluding any possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

Total \$

PART 2: MEMBER'S STATEMENT

Policyholder's name _____ Policy no.

Member's last name _____ First name _____

Certificate no. Date of birth Sex: M F
 Language: E F

COORDINATION OF BENEFITS

If one of your dependents is covered under another plan for dental care benefit, the expenses incurred by your dependent must first be submitted to the other insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.

The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.

Are you or your dependents, if applicable, covered by another group plan? No Yes If yes, specify:

Name of insurance company _____ Policy no. _____ Coverage: Individual Family
 Name of spouse or child _____ Date of birth

***Health Spending Account (HSA)**

Do you wish the unpaid portion of any expense provided for under the group policy to be paid under your HSA? Yes No

If yes, please indicate which expenses you wish to have the unpaid portion paid under your HSA by checking off the box in the HSA column in Part 1 above.

All dental care expenses which are not provided for under your group policy may be paid under your HSA.

Note: If the person for whom the claim is applicable has coverage under another plan, you must first submit the expenses to the other carrier before requesting payment under your HSA.

