STANDARD LIFE

GROUP LIFE & HEALTH

DENTAL CLAIM FORM — ACCIDENTAL INJURY TO NATURAL TEETH

CLAIMS DEPARTMENT

MONTRÉAL
P.O. BOX 4002, POSTAL STATION B
MONTRÉAL, QUÉBEC H3B 4M2

TORONTO
P.O. BOX 4105, POSTAL STATION A
TORONTO, ONTARIO M5W 2P4

PARTICIPANT'S STATEMENT

1. Name of Contract Holder _____

   Contract No.: _____ Certificate Number: _____

   Participant's last name _____ First name _____

   Name at birth _____ Sex: ❑ M ❑ F

   Address _____ Language: ❑ Engl. ❑ Fr.

   City _____ Province _____ Postal code _____

   Date of birth D M Y _____ S.I.N. _____

2. If services are for a dependent, please indicate:

   Last name _____ First name _____

   Relationship to participant _____ Date of birth D M Y _____

   If your child has reached the age limit specified in the contract: Handicaped ❑ Student ❑ Full-Time ❑ Part-Time ❑

   Name of the school attended _____ From D M Y _____ to D M Y _____

   Telephone (___) _____

   The Standard Life Assurance Company of Canada reserves the right to confirm the above information with the school attended.

3. Is your spouse covered under an insurance plan with his/her employer? ❑ yes ❑ no

   If yes, please provide the following:

   Name of group health and dental carrier _____

   Contract/Plan No.: _____ Spouse's date of Birth: D M Y _____ Spouse's coverage: ❑ family ❑ single

4. **PLEASE GIVE THE FOLLOWING INFORMATION:**

   Date accident occurred: _____ Place accident occurred: _____

   _____

   Circumstances of the accident: _____

   Date of first treatment D M Y _____

   Who gave treatment? _____

   Does child have school insurance? Yes ❑ No ❑

   Is a claim being made to the WCB? Yes ❑ No ❑

5. I authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, insurer, employer, or any other person or organization in possession of information concerning myself to release to The Standard Life Assurance Company of Canada all medical, financial, or other information deemed relevant by Standard Life, for the assessment of my claim.

   I authorize The Standard Life Assurance Company of Canada to conduct all necessary investigations required in order to verify the validity of my claim. I accept that Standard Life or their authorized agents use the information provided in this form and prior claims under the same plan (if relevant) for the management of my claim and for statistical reports.

   I confirm being authorized by my dependents to act on their behalf for their expenses submitted in this claim.

   I consent to the use of my Social Insurance Number as my certificate number, and understand that it is my responsibility to contact my employer/plan administrator if I prefer to use another identification number.

   I certify that the information contained in this form is true, correct and complete and that the amounts shown on both the receipts and the form truly reflect the amounts actually paid for the medical care. In the event of any false statement, Standard Life will automatically reject this claim in all or in part.

   A photocopy of this authorization is valid as the original.

Participant's signature _____ Date D M Y _____

Injured person's signature _____ Date D M Y _____

HAVE YOUR DENTIST COMPLETE THE REVERSE SIDE.

G2019G-01-2005 GL

DENTIST'S STATEMENT

Dentist's Last Name _____ Given Names _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone: _____

Social Ins. Number: _____

Patient's Last name _____ Given Names _____

Address: _____ Apt.: _____

City: _____

Province: _____ Postal Code: _____

Any changes to the services or fees have to be initialed by dentist.

Date of Treatment D M Y	Int. Tooth Code	Procedure Code	Tooth Surfaces	Labora-tory Fees	Dentist's Fees	Total Fees Incurred	FOR USE OF PLAN ADMINISTRATOR %	%	%	
		Total Fees claimed ⇨								

1. Code number of teeth damaged as a result of the accident: _____
2. Condition of teeth following the accident. (Please enclose X-rays): _____
3. If treatment cannot be given immediately, specify the dates and nature of future treatment, as well as the reason for the delay: _____
4. Additional Information: _____

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that said treatment was necessary as a result of an accident.

Dentist's Signature _____ Speciality (if any) _____ Date _____