Retiree Plans

Johnston group

JG98-JG

DENTAL CLAIM

Please indicate your Firm & Certificate #

Firm #	Certificate #

DENTIST

Unique # _____ Spec. _____ Patient's Office Account # _____

Phone Number

PATIENT

Patient Name _____

Home Address _____

City _____

Province _____ Postal Code _____

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
						TOTAL FEE SUBMITTED		

This is an accurate statement of services performed and the total fee due and payable, errors and omissions excepted. **Dentist's Signature** _____

FOR DENTIST'S USE, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

OPTIONAL ASSIGNMENT OF BENEFITS

I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist.

Covered Individual's Signature _____

1. Name and address of Covered Individual _____

   Covered Individual's Date of Birth (YYYY/MM/DD) _____ Patient's Date of Birth (YYYY/MM/DD) _____
2. Patient's Relationship to Covered Individual _____
3. Are you or your dependents entitled to benefits under any other plan? ❑ No ❑ Yes If "Yes," family member insured _____

   Name of insuring company _____ Spouse's Date of Birth (YYYY/MM/DD) _____
4. Are any of the services provided as a result of an accident? ❑ No ❑ Yes

   If "Yes," provide the date and details of the accident. _____
5. Are you claiming for an over-age dependent? ❑ No ❑ Yes

   Child is ❑ physically/mentally handicapped (medical evidence may be requested)

   ❑ a student enrolled **full time** at (school's name) _____
6. If treatment is a denture, crown or bridge, is it an initial placement? ❑ No ❑ Yes

   If "No," provide the last placement date and reason for replacement. _____
7. Is any treatment required for orthodontic purposes? ❑ No ❑ Yes

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any. I authorize Co-operators Life Insurance Company, Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

Covered Individual's Signature _____ Date _____

ALL INFORMATION ON THIS FORM WILL BE TREATED AS CONFIDENTIAL

Retiree Plans

Johnston group

JG98-JG

DENTAL CLAIM

Instructions (Please read carefully)

The Dentist completes shaded areas. The Covered Individual completes all other sections. Please ensure all questions are answered or your claim may take longer to process.

Send completed claim form to National Service Centre,
1051 King Edward Street, Winnipeg, MB R3H 0R4
Telephone 1-800-893-7587 • Fax 1-877-526-2515 • info@johnstongroup.ca