



THE
Great-West Life
ASSURANCE COMPANY

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 NAME
	ADDRESS		APT.
	CITY	PROV.	POSTAL CODE

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PHONE NO. _____

SIGNATURE OF SUBSCRIBER

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

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY 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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE _____

DUPLICATE FORM ☐

[illegible]

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
1-800-263-5742
(519) 435-6903

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

TOTAL FEE SUBMITTED

PART 2 EMPLOYEE INFORMATION

PLAN NO. _____ DIVISION NO. _____ EMPLOYEE IDENTIFICATION NO. _____

NAME OF EMPLOYER _____

EMPLOYEE NAME _____ DATE OF BIRTH ____/____/____
Day Month Year

EMPLOYEE ADDRESS _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's Signature _____ Date _____

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you _____ 2. Patient's Date of Birth: ____ / ____ / ____

3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No

4. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No

b) If student, how many hours per week at school? _____

c) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____

5. a) Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If yes, name of family member insured _____ Relationship to employee _____

Name of other insurance company _____ Policy number _____

b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/____/____
Day Month Year

6. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location, and explain how accident happened

7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement