



DENTALCARE

HEALTHCARE SPENDING ACCOUNT PLAN (SIDE 1)

Canadian Life and Health Insurance Association



Please print

PART 1 DENTIST. Fields include: UNIQUE NO, SPEC, PATIENT'S OFFICE ACCOUNT NO, LAST NAME, GIVEN NAME, ADDRESS, APT., CITY, PROV., POSTAL CODE, PHONE NO. Includes a signature line for the subscriber.

FOR DENTIST'S USE ONLY. Includes a section for diagnosis/procedures and a section for patient acknowledgment of fees and release of information. Includes a signature line for the patient/guardian.

Table with columns: DATE OF SERVICE (DAY, MO, YR), PROCEDURE CODE, INTL TOOTH CODE, TOOTH SURFACES, DENTIST'S FEE, LABORATORY CHARGE, TOTAL CHARGES. Includes a 'TOTAL FEE SUBMITTED' row at the bottom.

INSTRUCTIONS FOR CLAIM SUBMISSION. IMPORTANT: All claims under this group benefits plan are submitted through the plan member. Includes a list of 3 steps for claim submission and the Great-West Life logo.

PART 2 EMPLOYEE INFORMATION

Employee Name, Date of Birth, Employee Address, Group or Plan Name (HALIFAX PORT I.L.A. / H.E.A. WELFARE TRUST FUND), Plan Number (56072), Work Card Number, DIV #.

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.

Employee's Signature, Date

PART 3 PATIENT INFORMATION

1. Patient's Name, 2. Patient's relationship to employee, 3. Patient's Date of Birth. 4. If the patient is a child, does the patient reside with you? 5. If the child is over 18: a) Is he/she a full-time student? b) Is he/she employed? 6. If patient is other than employee's spouse or a child under 21, is employee entitled to claim a medical expense taxcredit... 7. a) Are you or any other member of your family entitled to dental benefits from any other plan? b) Is any member of your family (other than yourself) insured as an employee under this plan? c) If yes to questions 7 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth. 8. Is this treatment required as the result of an accident? 9. If claim is for denture, crown or bridge, is this initial placement?