

DENTAL CLAIM FORM

All claims must be submitted to insurer at the address below within 6 months from the date on which the expenses are incurred and no later than November 30th, 2026. Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

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 _____ SIGNATURE OF SUBSCRIBER																																																																																																																															
PATIENT				DENTIST																																																																																																																																			
PHONE NO.				PHONE NO.																																																																																																																																			
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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST AND THE PLAN MEMBER. _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)																																																																																																																																			
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DUPLICATE FORM ☐ <table border="1" style="width:100%; border-collapse: collapse; font-size: 0.8em;"> <tr> <th colspan="3">DATE OF SERVICE</th> <th rowspan="2">PROCEDURE CODE</th> <th rowspan="2">INT'L TOOTH CODE</th> <th rowspan="2">TOOTH SURFACES</th> <th rowspan="2">DENTIST'S FEE</th> <th rowspan="2">LABORATORY CHARGE</th> <th rowspan="2">TOTAL CHARGES</th> <th colspan="4">FOR CARRIER USE</th> </tr> <tr> <th>DAY</th> <th>MO.</th> <th>YR.</th> <th>ALLOWED AMOUNT</th> <th>INC.</th> <th>%</th> <th>PATIENT'S SHARE</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.</td> <td colspan="6">TOTAL FEE SUBMITTED</td> <td colspan="2">CLAIM NO.</td> <td colspan="2"></td> </tr> </table>												DATE OF SERVICE			PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE				DAY	MO.	YR.	ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE																																																																																												THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.			TOTAL FEE SUBMITTED						CLAIM NO.			
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PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER			
1. GROUP POLICY / PLAN NO. <u>100006</u> DIVISION / SECTION NO. _____		2. YOUR NAME (PLEASE PRINT) _____	
INSTITUTION <u>FLEMING COLLEGE</u>		CERTIFICATE # _____ Q	
NAME OF INSURING AGENCY OR PLAN <u>SMS, a division of IA Financial</u>		YOUR DATE OF BIRTH _____	
		DAY MONTH YEAR	

PART 3 – PATIENT INFORMATION			
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____		3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS ☐ NO ☐ YES	
DATE OF BIRTH _____		4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ☐ NO ☐ YES	
DAY MONTH YEAR		5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES	
IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐		6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE	
IF STUDENT, INDICATE SCHOOL _____		DATE _____	
PATIENT I.D. NO. _____		DAY MONTH YEAR	
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN ☐ NO ☐ YES		SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER _____	
POLICY NO. _____ SPOUSE DATE OF BIRTH _____			
NAME OF OTHER INSURING AGENCY OR PLAN _____			

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)																					
1. DATE COVERAGE COMMENCED 2. DATE DEPENDENT COVERED 3. DATE TERMINATED		DAY			MONTH			YEAR			CONTRACT HOLDER	DAY			MONTH			YEAR			AUTHORIZED SIGNATURE (POSITION OR TITLE)

PLEASE MAIL FORM TO:

CLAIMSECURE INC. PO BOX 6500 STN A SUDBURY ON P3A 5N5 • 1-888-513-4464

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER. NOTE: DO NOT STAPLE OR TAPE RECEIPTS TO THE CLAIM FORM.