Dental & Health Spending Account Claim Form

Approved by the Canadian Dental Association

Clear

1 To be completed by Dentist

PATIENT	Last Name	Given Name	Unique Number	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.
	Address	Apt.	DENTIST			
	City	Prov. Postal Code	Phone No.:			Signature of Subscriber

For Dentist's Use Only - For additional information, diagnosis, procedures, or special consideration.

Duplicate Form ☐

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 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.

Signature of Patient (Parent/Guardian) _____

Office Verification/Dentist's Signature _____

Date of Service Day	Month	Year	Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable E & OE

TOTAL FEE SUBMITTED

For Plan Administrator Use Only

2 Information about you – *be sure to fully complete this section*

Contract number	Employee ID number (first eight digits only)	Your plan sponsor/employer	Preferred language of correspondence
14178		**Royal Bank of Canada**	☐ English ☐ French

Your last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)	Daytime phone number
			– –	– –

Your address (street number and name)	Apartment or suite	City	Province	Postal code

3 Spouse/partner and children covered by this claim – *complete this section if claim is for spouse/partner or child*

Spouse's/partner's last name	First name	Date of birth (yyyy-mm-dd)	☐ Male ☐ Female
		– –	

Child's name	Relationship to you	Date of birth (yyyy-mm-dd)	Complete for overage dependents (refer to benefit information for age limits)
	☐ Son ☐ Daughter	– –	☐ Disabled ☐ Full-time student

4 Co-ordination of benefits – *complete this section if your spouse/partner and/or children has coverage under any other dental plan or contract*

Is your spouse/partner or are your children covered for any of these expenses under any other dental plan or contract? ☐ No ☐ Yes

If yes,:
- You must submit a claim for your spouse/partner to his/her plan first.
- You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year.

If your spouse's/partner's plan is also with us, complete the following:

Contract number	Member ID number	Spouse's/partner's date of birth (yyyy-mm-dd)	Do you want us to co-ordinate benefits (process both claims)?
		– –	☐ No ☐ Yes

If yes, spouse's/partner's signature	Date (yyyy-mm-dd)
X	– –

5 Health Spending Account – *complete this section if you are covered with a Health Spending Account*

If you're covered under more than one benefits plan, you should consider submitting your claim to the other plan(s) before using your HSA. If you are using your HSA to claim for the unpaid amount previously submitted to this or another plan, attach the claim statement you received and a copy of the receipts. Please select one of the following:

☐ You **don't** want to use your HSA for this claim

☐ You want us to assess this claim under your HSA **only**.

☐ You want us to assess this claim under your Dental care benefit **first** and then assess any unpaid balance under your HSA.

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6 Details of claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

1. Are any expenses the result of an accident? ☐ No ☐ Yes If yes, complete the following:

When did the accident occur? (yyyy-mm-dd)	Where did the accident occur?	How did the accident occur?
– –	☐ Work ☐ Home ☐ Other	

2. Is this treatment for orthodontic purposes? ☐ No ☐ Yes Implants? ☐ No ☐ Yes

3. Crowns, Bridges, Dentures Is this the initial placement? ☐ No ☐ Yes

If No, date of prior placement (yyyy-mm-dd)	Reason for replacement	If Yes, date teeth were extracted (for denture or bridge) (yyyy-mm-dd)
– –		– –

Please include the following to facilitate handling of your claim:

- Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays)
- List of all missing teeth (for bridges only)

7 Authorization and signature – *you must complete this section*

I certify that all goods and services being claimed have been received by me and/or my spouse/partner or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse/partner and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada ("Sun Life") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse/partner and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and that information about me, my spouse/partner and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

If I am making a claim under my Health Spending Account, I certify that these expenses qualify for reimbursement.

I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse/partner and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. I also understand that my plan sponsor may have access to a summary of the total amounts claimed by me under my Health Spending Account for the purposes of tax or administrative reporting.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

Member's signature	Date (yyyy-mm-dd)
X	– –

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Questions? For information about your coverage, visit the Sun Life website at *www.sunlife.ca* or call 1-800-305-5905, Monday to Friday from 8 a.m. to 8 p.m. ET.

Mailing instructions – *keep a copy of your claim form and receipts for your records*

Mail the completed form to:

Sun Life Assurance Company of Canada
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6

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