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According to your region, please submit complete form to:  
Ontario, Atlantic and Western Provinces  
PO Box 4643, Station A  
Toronto, Ontario M5W 5E3

**PART 1: DENTIST'S STATEMENT**

Patient (Last and first name)  
\_\_\_\_\_

Dentist (Last and first name / Address / Phone no.)  
\_\_\_\_\_

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

For dentist's use only to provide additional information, diagnosis, procedures, or special considerations:  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of subscriber

I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$\_\_\_\_\_ is accurate and has been charged to me for services rendered.

Duplicate  Predetermination

Member's signature \_\_\_\_\_

Verification (Dentist) \_\_\_\_\_

**Treatment and services rendered to the patient**

Date of service			Procedure code	Internal tooth code	Tooth surfaces	Dentist's fees	Laboratory charges	Total charges
Y	M	D						

Excluding possible errors or omissions, this is an accurate statement of services performed and the total fee due and payable.

**Total fee submitted**

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**PART 2: MEMBER'S STATEMENT**

Policyholder's name **Memorial University of Newfoundland Students' Union**

Policy no. 2 4 1 1 4 Division no. \_\_\_\_\_ Class no. \_\_\_\_\_

Member's last name \_\_\_\_\_ First name \_\_\_\_\_

Certificate no. \_\_\_\_\_ Date of birth 

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 Sex:  M  F Language:  E  F

**COORDINATION OF BENEFITS**

**IMPORTANT NOTE:**

*Under the coordination of benefits section of your plan, if your spouse is covered under a dental care benefit, the expenses incurred by your spouse must first be submitted to his or her insurer. You may subsequently submit a claim for the balance, if applicable, under your plan.*

*The expenses incurred by insured dependent children must be submitted to the plan of the parent whose birthday comes first during a calendar year.*

Is your spouse, if applicable, covered by another group plan?  No  Yes, specify:

Name of insurance company \_\_\_\_\_ Policy no. \_\_\_\_\_ Coverage:  Individual  Family

Name of Spouse \_\_\_\_\_ Date of birth 

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1. If expenses are incurred for a dependent, specify:

Last name \_\_\_\_\_ First name \_\_\_\_\_

Relationship to member \_\_\_\_\_ Date of birth 

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Children 21 and over:  Handicapped  Full-time Student Name of school \_\_\_\_\_

2. If the claim is the result of an accident, specify:  Work  Motor vehicle  Other and complete the "Dental Care in case of an accident" form (F54-267A)

