CANADIAN ELEVATOR INDUSTRY WELFARE PLAN

NOTE: Receipts for services claimed Below must be attached to this Form.

STANDARD DENTAL CLAIM FORM

Approved by Canadian Dental Association

PART 1 - DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

PATIENT: LAST NAME | GIVEN NAME | ADDRESS | APT. | CITY | PROV. | POSTAL CODE

DENTIST: PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

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 CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE			PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						

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

TOTAL FEE SUBMITTED

PLEASE SUBMIT COMPLETED CLAIM FORM TO:

Manion, Wilkins & Associates Ltd
626 - 21 Four Seasons Place, Etobicoke ON
M9B 0A6
416-234-3511
1-800-263-5621 (Toll Free)

RE: X-RAYS: PROPER ASSESSMENT OF THIS CLAIM WILL BE FACILITED BY INCLUSION OF X-RAYS FOR MAJOR TREATMENT

NOTE: PAYMENT IS MADE ONLY TO PLAN MEMBER

PART 2 - MEMBER INFORMATION

PLAN NUMBER

3000

CERTIFICATE NUMBER

NAME ( ) MR. ( ) MRS. ( ) MS. | SURNAME | GIVEN NAME | DATE OF BIRTH: DAY MO. YR.

ADDRESS: NUMBER & STREET | APARTMENT

CITY | PROVINCE | POSTAL CODE

IS THIS CLAIM FOR SERVICES REQUIRED AS THE RESULT OF AN ACCIDENT? ( ) YES ( ) NO
IF YES, HOW DID IT HAPPEN?
IF YES, IS ANY SCHOOL OR ANY OTHER MEDICAL PLAN INVOLVED?
IF SO, NAME OF CARRIER AND DETAILS OF THEIR PAYMENT ARE REQUIRED.

DATE OF ACCIDENT: DAY MONTH YEAR

WHERE DID IT HAPPEN?
( ) AT HOME ( ) AT WORK ( ) ELSEWHERE

IF CLAIM IS FOR A DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ( ) YES ( ) NO
IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ____

NAME OF PRESENT EMPLOYER ____

I AM CURRENTLY RECEIVING BENEFITS UNDER U.I.C. ❑ W.C.B. ❑

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR A DEPENDENT

DEPENDENT NAME | RELATIONSHIP ( ) SPOUSE ( ) SON ( ) DAUGHTER | DATE OF BIRTH: DAY MO. YR. | IF DEP. CHILD IS OVER 19 ( ) STUDENT ( ) HANDICAPPED

IS SPOUSE EMPLOYED? ( ) YES ( ) NO
IF YES, NAME AND DATE OF BIRTH OF SPOUSE, NAME OF EMPLOYER AND NAME OF INSURANCE CARRIER

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE PLAN ADMINISTRATOR WILL USE THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM STRICTLY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE THE PLAN ADMINISTRATOR TO EVALUATE OR INVESTIGATE MY CLAIMS AND RELEASE MY PERSONAL INFORMATION (INCLUDING HEALTH INFORMATION) TO QUALIFIED THIRD PARTIES SOLELY FOR THE PURPOSE OF CONDUCTING SUCH EVALUATIONS OR INVESTIGATIONS, AND ONLY TO THE EXTENT REQUIRED FOR SUCH PURPOSES. I HEREBY AUTHORIZE MY UNION, PHYSICIAN OR OTHER HEALTH PROFESSIONALS, ANY MEDICAL FACILITY, ANY INSURANCE COMPANY OR GOVERNMENT BODY, AND ANY OTHER PERSON OR INSTITUTIONS TO RELEASE RELEVANT INFORMATION TO THE PLAN ADMINISTRATOR SOLELY FOR THE PURPOSE OF PROCESSING THIS CLAIM. A PHOTOCOPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF MEMBER | DATE

NOTE: THIS CLAIM WILL NOT BE ACCEPTED FOR PAYMENT BY THE PLAN UNLESS THIS FORM IS FULLY COMPLETED AND SIGNED BY THE **MEMBER.**