# NO FRILLS/UFCW LOCAL 1000A BENEFIT TRUST FUND

## NO FRILLS/UFCW LOCAL 1000A BENEFIT PLAN

## DENTAL CLAIM FORM

NO FRILLS/UFCW BENEFIT TRUST FUND

**Send This Claim To:**
**PBAS**
**110-61 International Blvd.**
**Toronto, ON M9W 6K4**
**(416) 674-3350 / 1(800) 461-4361**

## 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.

PATIENT
Name
Address
City/Province Postal Code

DENTIST

SIGNATURE OF PLAN MEMBER

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 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

| Date of Service Day Mo. Yr. | 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** _____

## INSTRUCTIONS

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBITTED FOR PREDETERMINATION OF BENEFITS.

ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, FLUORIDE TREATMENT, X-RAY, BASIC RESTORATIONS AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PREDETERMINATION OF BENEFITS.

## PART 2 – PLAN MEMBER

1. Plan Number: **850** Division Section No. **N/A**

2. Member Name:

Social Insurance Number:

Employer Name:

Date of Birth : / / Day Month Year

## PART 3 – PATIENT INFORMATION

1. Patient's Relationship to Plan Member:

Date of Birth (DD/MM/YY)

Student __ Disabled __

If student, indicate school

2. Are any dental benefits or services provided under any other Group Insurance or Dental Plan, WSIB or Gov't Plan? No __ Yes __

Policy No. Spouse's Date of Birth:

Name of other Insuring Agency or Plan:

3. Is any treatment required as a result of an accident? No __ Yes __
If yes, give date and details separately.

4. If denture, crown or bridge, is this initial placement? No __ Yes __
Give date of prior placement and reason for replacement.

5. Is any treatment required for orthodontic purposes? No __ Yes __

6. I authorize the release of any information or records requested in respect of this claim to the plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

**SIGNATURE OF PLAN MEMBER** **/ DATE**

**All information recorded on this form is confidential.**

**Please see reverse side for Certification And Consent**

Revised September 2022

# CERTIFICATION AND CONSENT

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the dental services, identified by my dentist on the reverse side of this form, were incurred by me, or on account of one of my eligible dependants.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that personal information about me and that of my eligible dependants, as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; compute my benefits; satisfy any reporting requirements of the provincial and federal governments; comply with civil and criminal law; estimate future operating costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board Of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependants who are under 18 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependants, who are under 18 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependants under 18 years of age, have coverage through another plan, I hereby authorize the Trustees to disclose personal information about me and my dependants in order to determine eligibility for coverage in the settlement of claims.

A photostatic copy of this authorization will be as valid as the original.

_____ _____

Signature of Plan Member Date

If an expense has been incurred by an eligible dependant child age 18 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

_____ _____

Signature of Dependant
Child Age 18 or Over

Date

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