LIUNA LOCAL 1059 BENEFIT TRUST FUND

Agent/ Administrator **Global Benefits**
88 St. Regis Crescent South, Toronto, Ontario M3J 1Y8
Telephone: 416-635-6000 • Fax: 416-635-6464

STANDARD DENTAL CLAIM FORM

CANADIAN DENTAL ASSOCIATION

PART 1 DENTIST

UNIQUE NO.	SPEC.	PATIENTS OFFICE ACCOUNT NO.

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

SIGNATURE OF SUSCRIBER

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

DENTIST: 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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

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

FOR CARRIER USE

ELIGIBLE
TERM/O.O.B.
REINSTATED

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

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1 **2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.**

PART 2 – MEMBER

1. CONTROL NO/PLAN NO. 1059 BRANCH NO. _____ ☐ INITIAL CLAIM? ☐ SUBSEQUENT?
PRESENT EMPLOYER _____ TELEPHONE NUMBER: HOME _____ BUS. _____
2. NAME OF MEMBER _____ MEMBER'S DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____
ADDRESS OF MEMBER _____ MEMBER'S SOCIAL INSURANCE NUMBER _____

PART 3 – PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE _____
DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____
PATIENT'S OCCUPATION _____
2. IF CLAIM IS FOR THE DEPENDENT CHILD, IS THAT CHILD
HANDICAPPED? ☐ YES ☐ NO MARRIED? ☐ YES ☐ NO
A FULL TIME STUDENT? ☐ YES ☐ NO EMPLOYED? ☐ YES ☐ NO
ARE YOU ENTITLED TO AN INCOME TAX EXEMPTION FOR THIS DEPENDENT? ☐ YES ☐ NO
NAME AND ADDRESS OF DEPENDENT'S EMPLOYER _____
3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES? ☐ NO ☐ YES IF "YES", PROVIDE:
POLICY NUMBER: _____
NAME OF INSURER: _____
SPOUSE'S NAME: _____
SPOUSE'S DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____

4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO
5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO
GIVE DATE AND DETAILS _____
B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO
6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN
A) IS THIS THE INITIAL PLACEMENT?
UPPER ☐ YES ☐ NO LOWER ☐ YES ☐ NO
B) IF "NO" GIVE THE DATE OF PRIOR REPLACEMENT AND THE REASON FOR REPLACEMENT
C) DATE OF EXTRACTIONS _____

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

DATE _____ SIGNATURE OF MEMBER _____ TELEPHONE NUMBER *(INCLUDE AREA CODE)* _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

1405-1509-DCF 04/12

LIUNA LOCAL 1059 BENEFIT TRUST FUND

Dental Claim Form

Agent/
Administrator

Global Benefits
88 St. Regis Crescent South, Toronto, Ontario M3J 1Y8
Telephone: 416-635-6000 • Fax: 416-635-6464

CLAIM INSTRUCTIONS

1. To avoid delays in processing your claim, be sure all statements on the reverse are answered in full and have your dentist complete the other side of this form.

2. Re predetermination: If your dentist recommends a course of treatment involving fees of $300.00 OR MORE, his treatment plan, with X-rays, must be forwarded to the Plan's Administrator for predetermination of benefits before treatment begins. The Administrator will then advise both you and your dentist what the Plan will pay and therefore what, if anything, you will have to pay out of your own pocket.

3. Send all correspondence, this claim form, etc. to the Administrator:
   GLOBAL BENEFITS – CLAIMS DEPARTMENT
   88 ST. REGIS CRESCENT SOUTH
   Toronto, Ontario M3J 1Y8
   Telephone: 416-635-6000 Fax: 416-635-6464

PLEASE NOTE:
Your Policy contains a Coordination of Benefits Provision which may allow you to receive reimbursement from both plans up to a maximum amount equal to the amount charged on the claim. The provision also determines which Insurance Carrier will be designated as First Payor, and which will be designated as Second Payor. Generally speaking, any plan which covers an individual either as the insured employee, or in the case of children, as the dependent of the spouse with the earliest birth date (day and month) in the calendar year, is designated as the First Payor. All claims should be first submitted to the company who is the First Payor.