SASKATCHEWAN UNITED FOOD AND COMMERCIAL WORKERS DENTAL BENEFIT PLAN

P.O. Box 764, Winnipeg, Manitoba R3C 2L4
Telephone: 1-800-665-0122

STATEMENT OF CLAIM

This Claim Form Must be Completed Each Time An Eligible Expense Is Submitted For Payment. A Separate Claim Form Is Required For Each Member and Each Member's Dependent For Whom An Expense Has Been Incurred.

MEMBER'S STATEMENT

Member's Name _____ Social Insurance Number _____

Address _____
(Street No. and Name) (City or Town) (Province) (Postal Code)

☐ Please check if your address has changed in the past 12 months

Name of Employer _____

Expense Incurred on Behalf of _____ Relationship _____ Date of Birth _____

If you are claiming for a dependent child who is age 18 or older please indicate if:

☐ Handicapped

☐ Student following a full time course of education _____
(Name of Scholastic Institute and Please provide copy of student card or registration receipt.)

Is your spouse a member of this Plan? Yes ☐ No ☐

Are any dental benefits provided under any other group insurance or dental plans? Yes ☐ No ☐

If yes, Name of Family Member _____

Please provide Spouse's date of birth _____ | _____ | _____
Day Month Year

Plan Name or Insurer / Policy No. _____

Name and Address of Administrator _____

_____

Is claim made due to an accident?

☐ No

☐ Yes, If Yes, provide the following information:

Date of accident _____

How did accident happen? _____

Did it happen at work?

☐ No

☐ Yes. If Yes, please apply to Worker's Compensation Board for payment.

Are you or is your dependent entitled to benefits under any other plan for dental services required as a result of an accident?

☐ No ☐ Yes. If yes, please provide the following information:

Plan Name / Policy No. _____

Name and Address of Administrator _____

_____

I certify that the above statements are true and complete and hereby authorize the Plan, prepayment organization, employer, hospital, or dentist to release all information with respect to myself or my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. **I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED OR MAY EXCEED THE PLAN'S BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST / DENTURIST FOR THE ENTIRE COST OF THE TREATMENT.**

I authorize the use of my Social Insurance Number for identification purposes and as required by law for Income Tax reporting.

Date _____ 19____ _____
(Signature of Member)

UNION SUPPLY LABEL

DENTIST'S / DENTURIST'S STATEMENT

INSTRUCTIONS FOR CLAIM SUBMISSION

MEMBER: Please complete the reverse side of this claim form before submitting.

DENTIST / DENTURIST: When submitting a pre-determination DO NOT ENTER DATES OF SERVICE.
PRE-TREATMENT PERIAPICAL X-RAYS must be submitted for crowns, bridgework, inlays, onlays and veneers.
Please submit a copy of the original lab bill after completion of treatment.

PATIENT

DENTIST / DENTURIST PHONE NO. UNIQUE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST / DENTURIST.

Signature of Member

Date of Service DAY	MO.	YR.	INTL. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	DENTIST'S/ DENTURIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR PLAN ADMINISTRATOR USE ONLY COVERED AMOUNT BASIC	MAJOR	ORTHO
TOTAL FEE SUBMITTED											

1) NUMBER OF X-RAYS SUBMITTED:_____

2) IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

If no, give date of prior placement and reason for replacement _____

If Partial Denture, indicate teeth being replaced _____

3) IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO

4) WERE ANY SERVICES PERFORMED IN HOSPITAL? ☐ YES ☐ NO

ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURE, OR COMPLICATIONS:

DENTIST'S / DENTURIST'S CERTIFICATION:

This Statement is:

☐ A pre-determination only

☐ An accurate statement of services performed and fees charged E. & O.E.

DENTIST'S / DENTURIST'S SIGNATURE

I am a duly certified specialist in the field of _____