COUGHLIN
employee benefits specialists

Send all claims & enquiries to:
Coughlin & Associates Ltd., Plan Administrator
P.O. Box 764, Winnipeg, Manitoba, R3C 2L4
(204) 942-4438 Toll Free: 1(888)204-1234

DENTAL CLAIM FORM

PART 1 DENTIST / DENTURIST

NAME
ADDRESS
CITY, PROV
POSTAL CODE
TELEPHONE

UNIQUE NUMBER

PATIENT'S LAST NAME (PLEASE PRINT) | GIVEN NAMES
ADDRESS | APT.
CITY | PROV.
POSTAL CODE | TELEPHONE
☐ PLEASE CHECK IF ADDRESS HAS CHANGED IN PAST 12 MONTHS

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

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED. E. & OE.

TOTAL SUBMITTED FEE →

DENTIST / DENTURIST SIGNATURE | DATE | DAY | MONTH | YEAR

FOR DENTIST / DENTURIST USE ONLY FOR ADDITIONAL INFORMATION RE DIAGNOSIS, PROCEDURES, OR COMPLICATIONS, AND SPECIAL CONSIDERATIONS.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE 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 OR ITS AGENTS.

SIGNATURE OF PATIENT (OR PATIENT / GUARDIAN)

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

SIGNATURE OF INSURED MEMBER

FOR PLAN ADMINISTRATOR USE ONLY

FOR PLAN ADMINISTRATOR USE ONLY

TOTAL
DEDUCTIBLE
% COINSURANCE
PAYMENT

PART 2 INSURED MEMBER

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S / DENTURIST'S OFFICE

INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS CLAIM

1. GROUP POLICY NUMBER 240119
   GROUP PLAN NAME Iron Workers (Manitoba) L.U. 728

2. NAME OF INSURED MEMBER _____
   ADDRESS OF INSURED MEMBER _____

   MEMBER'S SOCIAL INSURANCE NUMBER ☐☐☐ - ☐☐☐ - ☐☐☐

3. PATIENT NAME _____ DATE OF BIRTH _____
   GENDER _____ RELATIONSHIP TO MEMBER _____

   IF CHILD AGE 21 OR OVER INDICATE *STUDENT ☐ HANDICAPPED ☐
   *Please provide proof of student attending Educational Institution

DATE _____

4. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLANS? YES ☐ NO ☐
   IF YES, INDICATE WHO IS INSURED UNDER THE OTHER PLAN. SELF ☐ SPOUSE ☐
   IF SPOUSE, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ___ ___ ___ (D M Y)
   EFFECTIVE DATE OF COVERAGE ___ ___ ___ (D M Y)
   NAME OF INSURER _____ POLICY NO. _____
   * NOTE For coordination of benefits, dependant children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.

5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO ☐ YES ☐
   GIVE DETAILS _____
   B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? NO ☐ YES ☐

6. IF DENTURE, BRIDGE OR CROWN IS THIS INITIAL PLACEMENT?
   UPPER YES ☐ NO ☐
   LOWER YES ☐ NO ☐
   IF YES, GIVE DATE OF EXTRACTION(S) _____
   IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
   DATE _____

7. I AUTHORIZE THE USE OF MY SOCIAL INSURANCE NUMBER FOR IDENTIFICATION PURPOSES AND, AS REQUIRED BY LAW, FOR INCOME TAX REPORTING. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF INSURED MEMBER _____

PART 3 HEALTHCARE SPENDING ACCOUNT

The Plan has recently revised its procedures whereby any remaining Health or Dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded an allowable maximum, etc.) are now automatically applied to the extent of your Healthcare Spending Account, if any, unless you indicate otherwise below. The exception would be in instances of co-ordination of benefits with your Spouse's Plan.

☐ Do not apply remaining claims expenses automatically to my H.S.A

EMPLOYEE AUTHORIZATION AND DECLARATION

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties; Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge

Date y ___ m ___ d ___ **Plan Member's Signature** _____

Protecting your personal information The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL