



Canadian Life and Health
Insurance Association



Health SolutionsPlus

Benefits to be paid from:

- ☐ Dentalcare Plan Only
☐ Health SolutionsPlus
☐ Both

INSTRUCTIONS

1. Complete page 1 and 2 of this form in full.
2. Sign and date the form.
3. Please retain copies for your files as original receipts will not be returned.
4. If you wish benefits to be paid directly to the dentist, sign the assignment portion of PART 1 below. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
5. Send to the appropriate Benefit Payment Office for your plan. See PART 7.

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

PART 1 - DENTIST INFORMATION - To be completed by Dentist

1

PATIENT		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. Signature of subscriber _____
Last name _____ Given name _____		DENTIST			
Address _____ Apt./Suite No. _____					
City _____ Prov. _____ Postal code _____					
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. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Duplicate form ☐

Signature of patient (parent/guardian) _____

Office verification _____

Date of Service Day Month Year	Procedure Code	Intl. tooth Code	Tooth Surfaces	Dentist Fees	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable, e. & o.e.

TOTAL FEE SUBMITTED \$ _____

PART 2 - Claim Details - To be completed by Dentist

2

Please specify claim details.

1. Is this treatment required as the result of an accident? ☐ Yes ☐ No

If yes, please provide:

Date: _____ Location: _____

Explain how accident happened

2. If claim is a denture, crown, or bridge, is this initial placement? ☐ Yes ☐ No

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

3. If claim is for a denture or bridge, please provide missing tooth number(s):

PLEASE COMPLETE PAGE 2 OF STATEMENT

PART 3 - Plan Member Information

3

You must complete this section fully.

If you are unsure of your plan name, plan number or plan member I.D. number, please contact your plan administrator.

Plan name			
Plan number		Plan member I.D. number	
Plan Member Name			
Last name		First name	
Plan Member Address			
Number and street			
City or town		Province	Postal code
Date of birth:	Day	Month	Year
			Language preference: <input type="checkbox"/> English <input type="checkbox"/> French

PART 4 - Coordination of benefits

4

Complete this section to indicate whether you or any member of your family have benefits coverage from any other plan.

1. Are you, or any member of your family, entitled to benefits under any other plan for the expenses being claimed? ☐ Yes ☐ No **If yes, please provide:**

Name of insurance company	If spouse's plan, please provide spouse's date of birth:		
	Day	Month	Year
Plan number			
Plan member I.D. number			

2. Is a claim being made for Workers' Compensation Benefits? ☐ Yes ☐ No

PART 5 - Patient information

5

Complete this section if claim is for spouse or dependant.

Patient name	Relationship to plan member	Date of birth Day Month Year	If child over 18 years		Does Patient Reside with Plan Member? Yes No
			Full time student hours per week	If employed, how many hours worked per week?	
			Yes No		Yes No

PART 6 - Authorization and Signature

6

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West life, located within or outside Canada, to exchange

personal information when necessary for these purposes.

I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

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

I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants.

I certify that I am claiming expenses that were incurred by myself or a person(s) for whom I am entitled to claim a medical expense credit under the Income Tax Act (Canada).

Plan Member signature X_____

Date:

Day	Month	Year
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PART 7 - Submitting Your Claim

7

Please send your claim to the Benefit Payment Office below. If blank, please consult your plan administrator for the address.

Dental Questions?
Call Toll Free: 1.855.729.1839
Health Solutions Plus Questions?
Call Toll Free: 1.877.883.7072

Winnipeg Benefit Payments
PO Box 3050
Winnipeg MB R3C 0E6
Canada



For the deaf or hard of hearing:
Toll Free: 1.800.990.6654