the co-operators®
A Better Place For You®

GROUP BENEFITS DENTAL CLAIM FORM

DENTAL

☐ **TREATMENT PLAN**
☐ **TREATMENT DUE TO ACCIDENT**

HEALTH SPENDING ACCOUNT (HSA)

☐ Reimburse any unpaid portion of this claim from my HSA
☐ Assign the payment from my HSA to the dentist

INSTRUCTIONS

Please mail your completed claim form and receipts to:
Co-operators Life Insurance Company
Dental Claims
1900 Albert Street
Regina, SK S4P 4K8

DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENT

You will receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Sign up for direct deposit and electronic claim statements by calling our Client Service Centre at 1-800-667-8164 or signing in to Benefits Now™.

PART 1 - DENTIST

PATIENT

Last Name Given Name

Address

City Province Postal Code

PROVIDER

Unique Number Specialty

Telephone Number:

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Plan Member Signature

Provider's Use Only - For additional information, diagnosis, procedures or special considerations.

Office Verification: _____
Dentist/Denturist Signature

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 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.

Patient (Parent/Guardian) Signature

DATE OF SERVICE (MMM/DD/YYYY)	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	PROFESSIONAL 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 $

PART 2 - PLAN MEMBER INFORMATION

Group **799** Account **00001** Certificate _____ Plan Sponsor/Employer _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

PART 3 - PATIENT INFORMATION

1. Relationship to Plan Member _____ Date of Birth _____ (MMM/DD/YYYY)

   If child, indicate ☐ Student ☐ Handicapped
   If a student, please ensure the annual Student Eligibility form has been completed and submitted.

2. Co-ordination of Benefits

   If this expense has been considered by another carrier, you **must** attach the original explanation of benefits from that plan along with **copies** of the receipts.

   Are you or your dependents covered by another plan? ☐ Yes ☐ No If yes, provide the following:

   Spouse Date of Birth _____ (Day) _____ (Month) Insurance Company Name/Source _____ Policy _____

   If your spouse's benefit plan is with Co-operators Life Insurance Company, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No

   Spouse's Policy _____ Certificate _____

3. Is any treatment required as a result of an accident? ☐ Yes ☐ No Date of Accident _____ (MMM/DD/YYYY)

   If yes, please ensure the Supplementary Dental Accident Report is completed and submitted. This form can be found on www.cooperators.ca or Benefits Now for Plan Members.

4. If denture, crown or bridge, is this initial placement? ☐ Yes ☐ No

   If no, give date of prior placement and reason _____

5. Is any treatment related to orthodontics? ☐ Yes ☐ No

(SEE REVERSE)

PART 5 - AUTHORIZATION

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefits plan. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. Any copy of this authorization shall be as valid as the original.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Co-operators Life Insurance Company may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers, and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

If Co-operators Life Insurance Company pays me an amount that exceeds the benefit(s) to which I am entitled under my plan (the Overpayment Amount), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for the Overpayment amount (b) Co-operators Life Insurance Company has the right to recover the Overpayment Amount through any means available by law, and (c) Co-operators Life Insurance Company will offset any benefits payable to me by the Overpayment Amount until Co-operators Life Insurance Company has recovered the Overpayment Amount in full.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

PART 6 - PRIVACY

Co-operators Life Insurance Company Privacy Statement

At The Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about The Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca