

PART 1 DENTIST

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

DENTIST UNIQUE NO. SPEC. PATIENT'S OFFICE ACCOUNT NO. PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST. SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION. DUPLICATE FORM

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. 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

Table with columns: DATE OF SERVICE (DAY, MO., YR.), PROCEDURE CODE, INTL. TOOTH CODE, TOOTH SURFACES, DENTIST'S FEE, LABORATORY CHARGE, TOTAL CHARGES

INSTRUCTIONS: All claims under this group benefits plan are submitted through the student. 1. Have your dentist complete Part 1. 2. Student completes Parts 2 and 3. 3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Questions? Call Toll Free: 1.800.957.9777

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

PART 2 STUDENT INFORMATION

Plan Number Division Number Student Identification Number Plan Name Student Name Date of birth Student address

At Canada 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. I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you 2. Patient's date of birth 3. If the patient is a child, does the patient reside with you? 4. If the child is over 18: a) Is the dependent a full-time student? b) If student, how many hours per week at school? c) Is the dependent employed? 5. a) Are you or any other member of your family entitled to benefits under any other plan? b) Is any member of your family (other than yourself) insured as a Student under this plan? c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth 6. Is this treatment required as the result of an accident? 7. Is a claim being made for Worker's Compensation Benefits? 8. If claim is for denture, crown or bridge, is this initial placement?