


PART 1 DENTIST		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.
P A T I E N T	LAST NAME	GIVEN NAME		SIGNATURE OF SUBSCRIBER	
	ADDRESS	APT.			
	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.			
DUPLICATE FORM <input type="checkbox"/>		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.			
		SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____			
		OFFICE VERIFICATION _____			

										INSTRUCTIONS	
DATE OF SERVICE			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES			
DAY	MO.	YR.									
										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. <ol style="list-style-type: none"> 1. Have your dentist complete Part 1. 2. Employee 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. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee. 4. Send this claim to: <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> Questions? Call Toll Free: 1.800.957.9777 </div> <p> Toronto Benefit Payments P.O. Box 4076 Stn A Toronto ON M5W 3A3 </p>  For the deaf or hard of hearing: Toll Free: 1.800.990.6654	

PART 2 EMPLOYEE INFORMATION	
Plan Number <u>57377</u> Division Number _____ Employee Identification Number _____	
Plan Name <u>WAYPOINT CENTRE FOR MENTAL HEALTH CARE</u>	
Employee Name _____ Date of birth ____ / ____ / ____	Day Month Year
Employee Address _____	
<p>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.</p> <p>I authorize Great-West Life, any healthcare 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.</p>	
Employee's Signature _____ Date _____	

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Day Month Year
4. If the child is over 18: a) Is he/she a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
b) If student, how many hours per week at school? _____	
c) Is he/she employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours worked per week? _____	
5. a) Are you or any other member of your family entitled to benefits under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of family member insured _____ Relationship to employee _____	
Name of other insurance company _____ Policy Number _____	
b) Is any member of your family (other than yourself) insured as an employee under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Day Month Year
If yes, give date, location, and explain how accident happened _____	
7. Is a claim being made for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. If claim is for denture, crown or bridge, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give date of prior placement and reason for replacement.	