When complete, please mail to:
The Great-West Life Assurance Company
London Benefit Payment Office
255 Dufferin Avenue
London, ON N6A 4K1

Long Distance Inquiries 1-800-318-6098

Kinectrics Inc.
Dental Claim for
Non-Management Employees and Pensioners

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.

Signature of Employee

Patient

Last Name | Given Name

Apt. | Street Address

City

Province | Postal Code

Dentist

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 form to my insuring company/plan administrator.

Signature of Patient (Parent/Guardian)

Office Verification

Duplicate Form ☐

Date of Service (day / month / year)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist s Fee	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 ▶

Instructions for Claim Submission

All parts of this form must be completed in full. If needed information is missing, the form may be returned to you.

1. Have the attending dentist complete Part 1
2. Complete Part 2 on each form sent in.
3. Mail all correspondence, claim forms, etc. to Great-West Life Assurance Company

Special Note:

If your Dentist recommends a course of treatment involving fees of $600.00 or more, his/her treatment plan may be submitted to Great-West Life Assurance Company in advance for predetermination of benefits. Great-West Life will inform you, before you undertake treatment of the amount allowed by the Plan.

Part 2 Employee Statement (complete this part before taking the form to your Dentist s Office)

1. Plan Number: **51597**

2. Marital Status
☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Widowed ☐ Common-law

3. Name of Employee:

Address of Employee:

Employee Number:

4. Patient s Name:

Patient s Date of Birth: Sex

Relationship to Employee:

If claim is for dependent child, is that child:
Married? ☐ Yes ☐ No
Enrolled as full-time student? ☐ Yes ☐ No

If yes, name of school:

Employed? ☐ Yes ☐ No

Handicapped? ☐ Yes ☐ No

5. Are any dental benefits or services provided under any other group insurance or dental plan?
☐ Yes ☐ No If Yes provide the following:

Is your spouse employed?
☐ Yes ☐ No

Spouse s Name:

Spouse s Date of Birth:

Spouse s Employer Name:

Spouse s Employer s Complete Address:

Name of Insurer:

Policy Number:

6. Is any treatment required as a result of an accident?
☐ Yes ☐ No
(a) Give date and details:

(b) Is claim being made to the Workplace Safety and Insurance Board? ☐ Yes ☐ No

7. If the treatment involves the placement of a bridge, denture or crown:
(a) Is this the initial placement: Upper ☐ Y ☐ N
Lower ☐ Y ☐ N
(b) If no, give the date of prior placement and reason for placement:

(c) Date of extractions:

8. Is any of the above work for orthodontic purposes? ☐ Yes ☐ No

9. 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.

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. 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 to exchange personal information when necessary for these purposes. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee/Pensioner Signature **Date**