COUGHLIN & ASSOCIATES LTD.

Send all claims & enquiries to:
Coughlin & Associates Ltd., Plan Administrator
P.O. Box 764, Winnipeg, Manitoba, R3C 2L4
(204) 942-4438 Toll Free: 1(888)204-1234

DENTAL CLAIM FORM

PART 1 DENTIST / DENTURIST

NAME
ADDRESS
CITY, PROV
POSTAL CODE
TELEPHONE

UNIQUE NUMBER

PATIENT'S LAST NAME (PLEASE PRINT) | GIVEN NAMES
ADDRESS | APT.
CITY | PROV.
POSTAL CODE | TELEPHONE
☐ PLEASE CHECK IF ADDRESS HAS CHANGED IN PAST 12 MONTHS

DATE OF SERVICE DAY	MO.	YR.	INT. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S /DENTURIST'S FEE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED. E. & O.E.

TOTAL SUBMITTED FEE ⟶

DENTIST / DENTURIST SIGNATURE | DATE | DAY | MONTH | YEAR

FOR DENTIST / DENTURIST USE ONLY FOR ADDITIONAL INFORMATION RE DIAGNOSIS, PROCEDURES, OR COMPLICATIONS, AND SPECIAL CONSIDERATIONS.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE 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 OR ITS AGENTS.

SIGNATURE OF PATIENT (OR PATIENT / GUARDIAN)

I HEREBY ASSIGN BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED DENTIST / DENTURIST.

SIGNATURE OF INSURED MEMBER

FOR PLAN ADMINISTRATOR USE ONLY

TOTAL
DEDUCTIBLE
COINSURANCE %
PAYMENT

PART 2 INSURED MEMBER

COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S DENTURIST'S OFFICE

INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS CLAIM

1. **GROUP POLICY NUMBER** 24979
   GROUP PLAN NAME IBEW Local 2038

2. **NAME OF INSURED MEMBER** _____
   ADDRESS OF INSURED MEMBER _____

   MEMBER'S SOCIAL INSURANCE NUMBER ☐☐☐ - ☐☐☐ - ☐☐☐

3. **PATIENT NAME** _____ **DATE OF BIRTH** _____
   GENDER _____ **RELATIONSHIP TO MEMBER** _____
   IF CHILD AGE 21 OR OVER INDICATE ***STUDENT** ☐ **HANDICAPPED** ☐
   ***Please provide proof of student attending Educational Institution**

DATE _____

4. **ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLANS?** YES ☐ NO ☐
   IF YES, INDICATE WHO IS INSURED UNDER THE OTHER PLAN. SELF ☐ SPOUSE ☐
   IF SPOUSE, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH D M Y
   EFFECTIVE DATE OF COVERAGE D M Y
   NAME OF INSURER _____ **POLICY NO.** _____
   *** NOTE** For coordination of benefits, dependant children must be claimed under the Plan of the parent with the earlier day and month of birth, in the calendar year.

5. **A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT?** NO ☐ YES ☐
   GIVE DETAILS _____
   B) IS CLAIM BEING MADE FOR WORKMEN'S COMPENSATION BENEFITS? NO ☐ YES ☐

6. **IF DENTURE, BRIDGE OR CROWN IS THIS INITIAL PLACEMENT?**
   UPPER YES ☐ NO ☐
   LOWER YES ☐ NO ☐
   IF YES, GIVE DATE OF EXTRACTION(S) _____
   IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
   DATE _____

7. **I AUTHORIZE THE USE OF MY SOCIAL INSURANCE NUMBER FOR IDENTIFICATION PURPOSES AND, AS REQUIRED BY LAW, FOR INCOME TAX REPORTING. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

SIGNATURE OF INSURED MEMBER _____

PART 3 HEALTHCARE SPENDING ACCOUNT

Any amount not eligible for reimbursement from the contents of this claim (e.g. deductible and co-insurance payment, claim that has exceeded an allowable maximum, health and dental expenses not covered under group insurance plan, etc.) is to be automatically applied to the extent of the balance in my Healthcare Spending Account, if any. ☐ YES ☐ NO

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

UNION LABEL