STUDENTCARE

Dental Claim Form

Approved by the Canadian Dental Association

Sun Life Financial

Clear

1 To be completed by Dentist

PATIENT

Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

Unique Number | Spec. | Patient's Office Account No.

DENTIST

Phone No.:

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

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 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 in this claim form to my insuring company / plan administrator.

Signature of Student **Mandatory**

Office Verification/Dentist's Signature

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 & OE

TOTAL FEE SUBMITTED

For Plan Administrator Use Only

2 To be completed by Insured Student – *be sure to fully complete this section*

Contract number	Student ID number	Group name	Preferred language of correspondence
22275		**AMS Dental Plan**	☐ English ☐ French

Your last name	First name	☐ Male ☐ Female	Date of birth (yyyy-mm-dd)	Daytime phone number

Your address (street number and name)	Apartment or suite	City	Province	Postal code

3 Spouse and children covered by this claim – *complete this section if claim is for spouse or child*

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	☐ Male ☐ Female

Child's name	Relationship to you ☐ Son ☐ Daughter	Date of birth (yyyy-mm-dd)	Complete for overage dependents (refer to benefit information for age limits) ☐ Disabled ☐ Full-time student

4 Co-ordination of benefits – *complete this section if your spouse and/or children has coverage under any other dental plan or contract*

Is your spouse or are your children covered for any of these expenses under any other dental plan or contract? ☐ No ☐ Yes

If yes,:
- You must submit a claim for your spouse to his/her plan first.
- You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year.

If your spouse's plan is also with us, complete the following:

Contract number	Member ID number	Spouse's date of birth (yyyy-mm-dd)	Do you want us to co-ordinate benefits (process both claims)? ☐ No ☐ Yes

If yes, spouse's signature	Date (yyyy-mm-dd)
X	

For SLF use:
DCF

5 Details of claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

Are any expenses the result of an accident? ☐ No ☐ Yes If yes, complete the following:

When did the accident occur? (yyyy-mm-dd)	Where did the accident occur? ☐ Work ☐ Home ☐ Other	How did the accident occur?
_ _		
Are any expenses the result of a condition covered by a workers' compensation program? ☐ No ☐ Yes		

6 Authorization and signature – *you must complete this section*

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada ("Sun Life") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life 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 there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I authorize Sun Life Assurance Company of Canada to disclose the information pertaining to this claim to Studentcare for benefits administration.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

Signature of Insured Student **(Mandatory)**	Date (yyyy-mm-dd)
X	_ _

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

Important:

All claims must be received by Sun Life Assurance Company of Canada no later than 90 days after the end of the policy year in which the claims were incurred or 90 days after the end of your coverage, whichever is sooner. For more information, refer to your booklet or get in touch with Studentcare. If you are under a treatment program which will involve a series of treatments for an extended period you should file a claim periodically and indicate on the claim form that it is part of an on-going treatment plan.

For details specific to your Plan, visit *www.studentcare.ca*

Mail your completed form to:

Sun Life Assurance Company of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6

Please retain a copy of your claim form and receipts for your records.

For SLF use:
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