UNITED FOOD AND COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN – ONTARIO

Send This Claim To:
PBAS
110-61 International Blvd.
Toronto, ON M9W 6K4

PART 1 DENTIST

Unique No. _____ Spec. _____ Patient's Account No. _____

PATIENT

Name _____

Address _____

City _____

Province _____ Postal _____

DENTIST

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 claim form to my 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)

Duplicate Form ☐

Office Verification

Date of Service	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Lab Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable. E & OE

Total Fee Submitted _____

INSTRUCTIONS

If charges will be $300 or more, your claim should be submitted for predetermination of benefits.

Routine oral examinations, scaling and cleaning, fluoride treatment, x-ray, basic restorations and emergency treatment may be performed by your dentist prior to submitting your claim for predetermination of benefits.

X-rays may be required to be submitted for crowns or bridgework. X-rays will be returned promptly to your dentist.

PART 2 – PLAN MEMBER

1. Group Plan No. _____

Employer _____

2. Member Name: _____

SIN No. _____

Date of Birth _____

PART 3 – PATIENT INFORMATION

1. Patient: Relationship to Plan Member: _____

Date of Birth: _____

If student, indicate school: _____

○ Student ○ Handicapped

2. Are any dental benefits or services provided under any other Group Insurance or Dental Plan, WSIB or Gov't Plan? ○ YES ○ NO

Policy No.: _____

Spouse's DOB: _____

Name of other Insuring Agency or Plan: _____

3. Is any treatment required as a result of an accident? ○ YES ○ NO
If yes, give date and details separately.

4. If denture, crown or bridge, is this initial placement? ○ YES ○ NO

Date of prior placement: _____

Reason: _____

5. Is any treatment required for orthodontic purposes? ○ YES ○ NO

6. I authorize the release of any information or records requested in respect of this claim to the insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

_____ _____
Signature Date

Certification And Consent

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the dental services, identified by my dentist on the reverse side of this form, were incurred by me, or on account of one of my eligible dependents.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in strictest confidence and will only be used for the specified purpose.

I understand that personal information about me and that of eligible dependents as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; compute my benefits an those of my eligible dependents; satisfy any reporting requirements of the provincial and federal government; comply with civil and criminal law; estimate future operation costs; assess Plan performance; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan.

I hereby authorize the Board of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependents who are under 18 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependents, who are under 18 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent of its use, at any time. However, I realize that if I withhold or revoke my consent for its use, thereby limiting or restricting the ability to determine coverage and benefit entitlements, may participation in the Plan my be impaired or cancelled.

If I, or my dependents under 18 years of age, have coverage through another plan, I hereby authorize the Trustees to disclose personal information about me and my dependents in order to determine eligibility for coverage in the settlement of claims.

A photostatic copy of this authorization will be as valid as the original.

Signature of Plan Member _____ Date _____

If an expense has been incurred by your eligible spouse, and is attached to this claim, please have your spouse sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

Signature of Spouse _____ Date _____

If an expense has been incurred by an eligible dependent child age 18 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

Signature of Dependent (Child Age 18 or Over) _____ Date _____

Signature of Dependent (Child Age 18 or Over) _____ Date _____