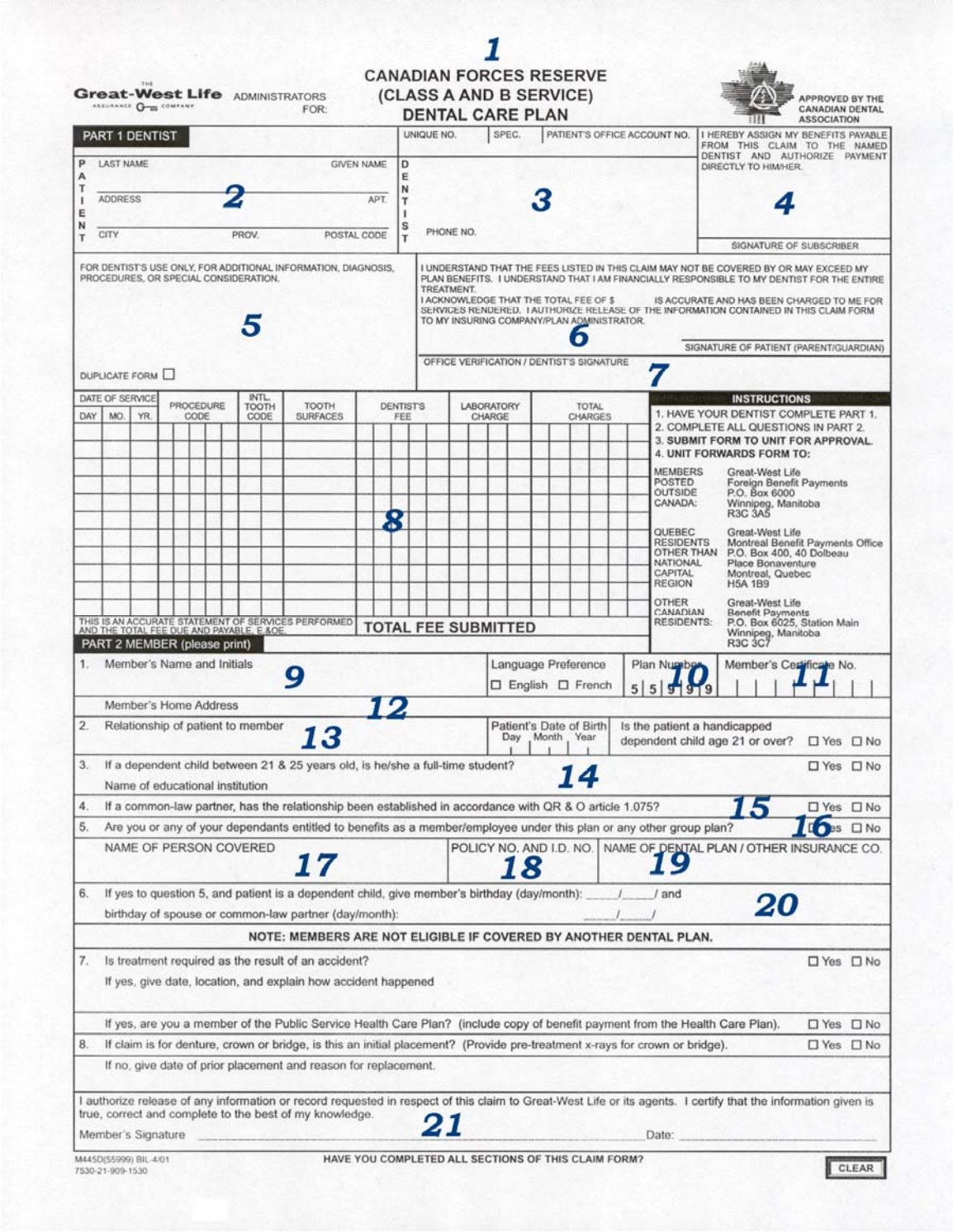
Annex E to RDCP Administration Manual



1

Great-West Life ASSURANCE COMPANY ADMINISTRATORS FOR:

CANADIAN FORCES RESERVE
(CLASS A AND B SERVICE)
DENTAL CARE PLAN

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

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.

4

SIGNATURE OF SUBSCRIBER

PATIENT: LAST NAME | GIVEN NAME

2

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

3

PHONE NO.

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

5

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 CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

6

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

7

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

8

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E.&O.E.

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. HAVE YOUR DENTIST COMPLETE PART 1.
2. COMPLETE ALL QUESTIONS IN PART 2.
3. **SUBMIT FORM TO UNIT FOR APPROVAL.**
4. **UNIT FORWARDS FORM TO:**

MEMBERS POSTED OUTSIDE CANADA: Great-West Life, Foreign Benefit Payments, P.O. Box 6000, Winnipeg, Manitoba R3C 3A5

QUEBEC RESIDENTS OTHER THAN NATIONAL CAPITAL REGION: Great-West Life, Montreal Benefit Payments Office, P.O. Box 400, 40 Dolbeau Place Bonaventure, Montreal, Quebec H5A 1B9

OTHER CANADIAN RESIDENTS: Great-West Life, Benefit Payments, P.O. Box 6025, Station Main, Winnipeg, Manitoba R3C 3C7

PART 2 MEMBER (please print)

1. Member's Name and Initials

9

Language Preference ☐ English ☐ French

Plan Number 5 5 9 9 9

10

Member's Certificate No.

11

Member's Home Address

12

2. Relationship of patient to member

13

Patient's Date of Birth Day | Month | Year

Is the patient a handicapped dependent child age 21 or over? ☐ Yes ☐ No

3. If a dependent child between 21 & 25 years old, is he/she a full-time student? ☐ Yes ☐ No

Name of educational institution

14

4. If a common-law partner, has the relationship been established in accordance with QR & O article 1.075? ☐ Yes ☐ No

15

5. Are you or any of your dependants entitled to benefits as a member/employee under this plan or any other group plan? ☐ Yes ☐ No

16

NAME OF PERSON COVERED	POLICY NO. AND I.D. NO.	NAME OF DENTAL PLAN / OTHER INSURANCE CO.
17	18	19

6. If yes to question 5, and patient is a dependent child, give member's birthday (day/month): ____/____/ and birthday of spouse or common-law partner (day/month): ____/____/

20

NOTE: MEMBERS ARE NOT ELIGIBLE IF COVERED BY ANOTHER DENTAL PLAN.

7. Is treatment required as the result of an accident? ☐ Yes ☐ No

If yes, give date, location, and explain how accident happened

If yes, are you a member of the Public Service Health Care Plan? (include copy of benefit payment from the Health Care Plan). ☐ Yes ☐ No

8. If claim is for denture, crown or bridge, is this an initial placement? (Provide pre-treatment x-rays for crown or bridge). ☐ Yes ☐ No

If no, give date of prior placement and reason for replacement.

I authorize release of any information or record requested in respect of this claim to Great-West Life or its agents. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's Signature

21

Date:

M445D(55999) BIL-4/01
7530-21-909-1530

HAVE YOU COMPLETED ALL SECTIONS OF THIS CLAIM FORM?

CLEAR

Member's aid leaflet - Completing a claim form

I. Claim Form

GWL has produced claim forms specifically designed for the RDCP. These forms are available through regular supply channels. GWL will accept Standard Dental Claim Forms, which can be obtained from your Dentist's Office or claim forms produced by the Dentist Office. It is highly

recommended that members use the RDCP claim form as it prompts the member to answer questions specific to the RDCP rules and provisions.

2. Patient Information

Ensure patient information is correctly entered. If your Dentist Office keeps a record of your dental information, advise the office of any changes.

3. Dentist Information

To provide GWL with the source of the dental services; this information is critical. (see 4 below)

4. Assigning payment directly to the dentist

The dentist may allow you to direct GWL to remit the payable benefit directly to the dentist. If so, signing here you are authorizing GWL to send the payment directly to the dentist and you will pay the dentist the outstanding balance.

5. Additional Information

If additional information or special consideration is required the dentist will use this space. If you wish to submit a claim for a "Pre-determination of benefits.' the dentist will indicate it within this box (see 6 for further information on Pre-determinations). If a claim is lost and you are re-submitting then the "Duplicate Form" box will be checked off.

6. Acknowledgement of Responsibility

By signing this block you are acknowledging that fees listed mayor may not be covered by the RDCP. You are financially responsible to the dentist for these fees and that the fees are accurate for the services rendered. Your signature also authorizes the release of the information contained on the claim form to the insuring company/plan administrator. For a "Pre-determination of benefits" you will not sign this block as the pre-determination is an estimate for proposed services and fees that have not been incurred.

7 .Office Verification/Dentist's Signature

Verification from the dentist office that all information given is accurate. This box must be completed by the dentist's office stamp/signature.

8. Statement of Services

Full particulars of service and applicable charges.

9. Member's Name and Initials

Ensure that you enter your name as the plan holder. GWL will cross-reference your name with the certificate number. Your claim will be returned to you by GWL if there is a discrepancy.

10. Plan Number

Ensure that the plan number is 55999 for the RDCP.

11. Member's Certificate No.

Ensure that you enter your initially assigned Certificate Number here. Additional Certificate Numbers, SN, SIN and ID numbers from other plans will not be accepted, and your claim will be returned to you.

12. Member's Home Address

The cheque from the claim shall be mailed to this address. Ensure that this address is correct. If you cannot be reached at the indicated address, GWL will retain your cheque until you notify them of the proper address.

13. Relationship of Patient

If you are on Class A or short-term Class B you may only claim "self'. If you are on long-term Class B you may only claim an eligible dependant, "spouse", "or child “or” common-law partner".

14. Dependant child over 21

Under this plan you may cover a dependant child up to the child's 21st birthday. If the child is a student enrolled full-time at an educational institution, you may cover him/her until their 25th birthday.

15. Common-law partner

Means a person who has been cohabiting with a member in a conjugal relationship for a period of at least one year or for a period less than one year, if the member and the person have jointly assumed the support of a child.

16. Benefits under another plan

If you indicate yes and you are the member/employee of the other plan you are not eligible and may not participate in the RDCP.

17 .Name of person covered

Indicate name of the member/employee of the other plan. If your spouse or common-law partner is the other policy holder and they are the patient, ensure that the dental expenses are first claimed through their plan. When submitting to cover the difference, attach a copy of the claim form and the "Statement of Benefits" from the other insurance company when you forward your claim to GWL.

18. Policy & ID No.

Ensure the other plan's policy number and the member's ID number, listed in the previous block is entered.

19. Name of dental plan/other insurance Co.

Indicate the name of the other plan and which insurance company administers the plan.

20. Coordinating benefits for a child

If your spouse or common-law partner is a member/employee of another plan and the claim is for your child, it is important to enter your date of birth and your spouse/partner's. When coordinating benefits between the two plans, the claim will be first paid under the plan of the individual who was born first in the calendar year and the difference under the other plan.

21. Signature and date

Once you have completed the entire claim form, and not just key areas highlighted here, you must sign and date the claim. There is no provision in the RDCP to allow spouses or common- law partners to sign the claim on your behalf. Claims not signed and dated by the member will be returned to you by GWL.

ENSURE YOUR ORDERLY ROOM STAMPS YOUR CLAIM WITH THE P RES HEALTH BENEFITS APPROVAL STAMP OR YOUR CLAIM WILL BE DENIED