ACCIDENTAL DENTAL CLAIM FORM

SSQ Insurance Company Inc.

Please answer all questions fully – it helps us to provide better service

Important - If the member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to the Dental plan. If there is any unpaid balance, please attach their payment statement(s).

Note – This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned to **SSQ Insurance Company Inc.** at any of the following addresses:

SSQ Place, 110 Sheppard Avenue East, Suite 500, Toronto, Ontario M2N 6Y8
2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5
800 - 6th Avenue S.W., suite 650, Calgary, Alberta T2P 3G3

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Part 1 – Dentist

Policy No.: .....

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

Patient's Name	**Dentist's Name**	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her.
Address	Address	.....
Telephone No: ( )	Telephone No: ( )	Signature of Subscriber

For Dentist use only ☐ **Duplicate** form
(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 insuring company / plan administrator.

....
Signature of patient (parent / guardian) ☐ Office Verification

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	**Total Charges**

For Carrier Use:

Allowed Amt.	Inc.	%	Patient's Share

Cheque No.	Date (D/M/Y)

Deductible	Patient Pays	Plan Pays

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

Total Fee Submitted:
$ .....

Claim Number .....

Part 2 – Dentist's Supplementary Report

1. Description of damage .....

2. Is further treatment indicated? ☐ Yes ☐ No If **Yes**, please indicate :

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

3. Describe further potential problems and indicate time frame. .....

4. A) How many teeth were injured? ..... B) Were these whole or sound teeth? ☐ Yes ☐ No C) How many of these teeth had fillings? .....
   D) How many of these injured teeth had crowns? ..... E) How many of these injured teeth had root canal treatment? .....
   F) If not whole or sound teeth, explain reason why .....

Dentist's Signature ..... Date D M Y .....

Part 3 – Dental Accident Supplementary Questionnaire for Insured Subscriber

Policy No.: .....

Date of accident D M Y ..... Time of accident? ..... ☐ a.m. ☐ p.m.

Where did accident occur? .....

Describe how accident occurred? .....

Nature of injury? .....

If taken to hospital, name of hospital? .....

Date admitted D M Y ..... Time ..... ☐ a.m. ☐ p.m.

Date discharged D M Y ..... Time ..... ☐ a.m. ☐ p.m.

Dentist's Name ..... Date first treated D M Y .....

Part 4 – Employee / Plan Member / Subscriber (if covered under other plans(s))

Your Name ..... Date of Birth D M Y .....

Group Policy / Plan Number ..... Division / Section Number .....

Employer .....

Name of insuring agency or plan .....

Part 5 – Patient Information

Patient ..... Relationship to Employee/Plan Member/Subscriber .....

Date of Birth D M Y ..... If child, indicate ☐ Student ☐ Handicapped

If student, indicate school .....

Do you have coverage for dental expenses under any of the following:

Group Health Plan? ☐ Yes ☐ No Plan Name/Policy No. .....

Group Dental Plan? ☐ Yes ☐ No Plan Name/Policy No. .....

W.C.B. Plan? ☐ Yes ☐ No Plan Name/Policy No. .....

Government Plan? ☐ Yes ☐ No Plan Name/Policy No. .....

I certify that to the best of my knowledge that the statements made above are true, correct and complete.

Signature of Plan Member/Subscriber ..... Date D M Y .....

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Part 6 – Policyholder / Employer (for completion only if applicable)

Date coverage commenced? D M Y ..... Date terminated D M Y .....

Date dependent covered? D M Y .....

Policyholder .....

Address .....

Signature of Policyholder/Employer ..... Print Name .....

Position/Title ..... Date D M Y ..... Telephone ( ) .....