STANDARD DENTAL CLAIM FORM

SSQ Insurance Company Inc.

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

Instructions to Insured Client: Complete the Insured's Statement Section on page 1.

Instructions to Dentist: Complete the Dental Claim Form on page 2

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.

Insured's Statement Section to be completed in full by the Insured Client **Policy No.:** .....

1. Insured's Name .....
2. Date of Birth D M Y .....
3. Dependent's Full Name | Relationship to Insured | Date of Birth

Dependent's Full Name	Relationship to Insured	Date of Birth
		D M Y
		D M Y
		D M Y

(If space is insufficient, please use a separate sheet of paper)

4. Name and address of post-secondary school he/she is currently attending if dependent child is age 21 or older.

Please include Proof of Registration/Enrollment

5. Complete address in Canada

Number & Street City Province Postal Code

6. Complete address outside of Canada .....

7. Are you or your dependents eligible for benefits under any Provincial Health Plan? ☐ Yes ☐ No
   (a) If Yes, Provincial Health Plan No. .....
   (b) Any other Medical or Dental Plan? ☐ Yes ☐ No Type of Coverage .....
8. Name of eligible family member ..... 9. Relationship .....
10. Name of Insurance Company Administering the Plan .....
    Policy/I.D. No. .....

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

Dental Claim Form

Part 1 – Dentist

Policy No.: .....

Unique No.	Spec.	Patient's Office Account Number
Patient's Name Address Telephone No: ( )	**Dentist's Name** Address Telephone No: ( )	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. ..... 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 Amount	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 involved? ..... 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 teeth had root canal treatment? .....
   F) If not whole or sound teeth, explain reason why .....

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