

INFORMATION ON THE PARTICIPANT

If the information contained in Section A is incorrect or incomplete, please fill in Section B.

A.

Group: _____
Employer: _____
Identification No.: _____

B.

Name: _____
Address: _____
Postal Code: _____
Phone: _____
Group: _____ Employer: _____
Identification No.: _____

IMPORTANT 1. For dependent child aged 18 to 26 years old, fill in section 2 on this form.
2. If dental services are necessary as the result of an accident, fill in section 3 on this form and include the x-ray(s).
3. Your claim form must be filled in within 12 months from the date dental expenses were incurred and services received.

1- INFORMATION ON THE PARTICIPANT:

Employer's name: _____
Participant's telephone number: at home _____
at work _____
Participant's date of birth _____
Y M D

Are any dental benefits or services provided under any other group insurance or dental plan, or government plan? No Yes
Policy No.: _____
Name of insuring agency: _____

INFORMATION ON THE PATIENT:

Relationship with the participant:
 spouse other child
Patient's date of birth _____
Y M D First name _____
Spouse's date of birth _____
Y M D

2- STUDENT CERTIFICATE FOR CHILD AGED OVER 17 OR 20 YEARS OLD ACCORDING TO YOUR POLICY

I hereby certify that my child _____ is unmarried and attends the secondary school, college or university _____
Name of institution for the fall session _____, or winter session _____, as a day student on a full time basis.
Year Year

3- DENTAL SERVICES REQUIRED AS THE RESULT OF AN ACCIDENT

No Yes If yes, indicate the date, _____
give some details, and enclose the **X-RAY(S)**. _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER AND CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ Y M D Participant's signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

(DENTAIRE-A) CPRDA1 (2017-11-29)

D E N T I S T	Name: Address: City, province: Postal Code: Phone No.: Licence:	Patient's Last Name Address City Postal Code	First Name(s) Apt. Province Phone No.
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N.B.: An official receipt or the professional's seal is required for reimbursement.

Date of treatment			Internat Tooth Code	Procedure code	Surface or Sextant	Laboratory Charge	Dentist's fee	Total Charge
Year	Month	Day						

Reserved for dentist's use for additional information on diagnosis, procedures complications and special considerations.

This is an accurate statement of services performed and fees charged, or of services to be performed and fees to be charged in the case of a treatment plan except errors and omissions.

 Dentist's signature

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 cost of the treatment. I authorize release of the information contained in this form to my insurance company or plan administrator.

 Signature of patient (or parent/guardian)

Total Fees Submitted

Date	Year	Month	Day	TOTAL

DUPLICATE FORM

Treatment Plan

This estimate is valid for 60 days only.
 Fees do not cover complications that may occur during and after treatment.
 Laboratory costs are approximate.

No date of treatment should appear on this form.

IMPORTANT

The participant must duly fill in the reverse of this form and sign it.

N.B.: An official receipt or the professional's seal is required for reimbursement.