beneva
by LaCapitale

Beneva
625 Jacques-Parizeau St
P.O. Box 1500
Quebec QC G1K 8X9

DENTAL INSURANCE CLAIM FORM

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)

INFORMATION ON THE PATIENT:

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

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: _____
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 _____ (First name) is unmarried and attends the secondary school, college or university _____ (Name of institution) for the ❑ fall session _____ (Year), or ❑ winter session _____ (Year), as a day student on a full time basis.

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)

Beneva designates La Capitale Civil Service Insurer Inc. as insurer.

DENTAL CLAIM FORM

STANDARD FORM
APPROVED BY QUÉBEC
DENTAL SURGEONS ASSOCIATION

DENTIST

Name:
Address:

City, province:
Postal Code:

Phone No.: Licence:

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

Patient's Last Name First Name(s)

Address Apt.

City Province

Postal Code Phone No.

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

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

Total Fees Submitted

Date Year Month Day **TOTAL**

❑ **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 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)

❑ 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.

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

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.

(DENTAIRE2-A)CPRDA2 (2013-01-09)

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