

Hosted by the Boilermakers' National Health Plan (Canada)

Phone: 1-800-263-3564 Fax: 905-946-2535

email: questions@boilermakers191benefits.org

Canadian Dental Association



Canadian Life and Health Insurance Association Inc.

PATIENT

LAST NAME		GIVEN NAME	
ADDRESS		APT.	
CITY	PROV.	POSTAL CODE	

UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.
D E N T I S T	PHONE NO.	

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO
THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO
THEM

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY — 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 THE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO THE PLAN, MY INSURER, AND MY POLICYHOLDER. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION IS TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE _____

DUPLICATE FORM ☐

[illegible]

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

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1. 3. ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU.
2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN. 4. ALL CORRESPONDENCE, CLAIM FORMS, ETC., ... MAIL TO: PLAN ADMINISTRATION OFFICE

PART 2 — MEMBER

1. CONTROL NO./PLAN NO. _____ BRANCH NO. _____ ADDRESS OF MEMBER _____

 EMPLOYER _____ MEMBER'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

2. NAME OF MEMBER _____ MEMBER'S SOCIAL
 INSURANCE NUMBER/IDENTITY NUMBER _____

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____ 2. IF CLAIM IS FOR DEPENDENT CHILD, IS THAT CHILD HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐ A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐ 3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES: ☐ YES NO ☐ IF "YES," PROVIDE: POLICY NUMBER: _____ NAME OF INSURER: _____ SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____ 4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐	5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐ GIVE DATE AND DETAILS _____ B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐ 6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN: A) IS THIS THE INITIAL PLACEMENT? UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐ B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT _____ C) DATE OF EXTRACTIONS _____ Privacy Statement: I authorize the Boilermakers Lodge No. 191 Benefit and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefit related information. Questions related to the Privacy Statement should be directed to the Privacy Officer MEMBER'S SIGNATURE: _____ DATE: YEAR _____ MONTH _____ DAY _____
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MEMBER'S SIGNATURE: _____

DATE: YEAR _____ MONTH _____ DAY _____