the co-operators®
A Better Place For You®

CO-OP®

GROUP BENEFITS
CO-OPERATIVE RETAILING SYSTEM
DENTAL CLAIM FORM

DENTAL

☐ **CLAIM** ☐ **TREATMENT PLAN**

INSTRUCTIONS

Please mail your completed claim form and receipts to:
Co-operators Life Insurance Company
Dental Claims
1920 College Avenue
Regina, SK S4P 1C4

DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENT

You will receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Sign up for direct deposit and electronic claim statements by calling our Client Service Centre at 1-800-667-8164 or signing in to Benefits Now™.

PART 1 - DENTIST

PATIENT

Last Name | Given Name

Address

City | Province | Postal Code

Patient ID Number

PROVIDER

Unique Number | Specialty

Telephone Number:

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Plan Member Signature

☐ Duplicate Form

Provider's Use Only - For additional information, diagnosis, procedures or special considerations.

Was this emergency treatment? ☐ Yes ☐ No If Yes, please provide additional details.

ATTACHMENTS: ☐ Radiographs (large/small) ☐ Models ☐ Photographs ☐ Written Diagnostic Report

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 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.

Patient (Parent/Guardian) Signature

Office Verification: _____
Dentist/Denturist Signature

DATE OF SERVICE (MMM/DD/YYYY)	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	PROFESSIONAL FEE	LABORATORY CHARGE	TOTAL CHARGES
This is an accurate statement of services performed and the total fee due and payable, E & OE.					**Total Fee Submitted**	$

PART 2 - PLAN MEMBER INFORMATION

Group **369** Account **00191** Certificate _____ Plan Sponsor/Employer _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

PART 3 - PATIENT INFORMATION

1. Relationship to Plan Member _____ Date of Birth _____ (MMM/DD/YYYY)

   If child, indicate ☐ Student ☐ Handicapped

2. Co-ordination of Benefits

   If this expense has been considered by another carrier, you **must** attach the original explanation of benefits from that plan along with **copies** of the receipts.
   Are you or your dependents covered by another plan? ☐ Yes ☐ No If yes, provide the following:

   Spouse Date of Birth _____ (Day) _____ (Month) Insurance Company Name/Source: _____ Policy: _____

   If your spouse's benefit plan is with Co-operators Life Insurance Company, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No

   Spouse's Policy _____ Certificate _____

3. Is any treatment related to an accident? ☐ Yes ☐ No
   If yes, a Supplementary Dental Accident Report form will be sent directly to your dental office for completion.

4. If denture, crown or bridge, is this initial placement? ☐ Yes ☐ No

   If no, give date of prior placement and reason _____

5. Is any treatment related to orthodontics? ☐ Yes ☐ No

(SEE REVERSE)

PART 4 - PRIVACY AND AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependent to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependents for such purposes. Any copy of this authorization shall be as valid as the original.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Co-operators Life Insurance Company may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers, and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

If Co-operators Life Insurance Company pays me an amount that exceeds the benefit(s) to which I am entitled under my plan (the Overpayment Amount), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for the Overpayment amount (b) Co-operators Life Insurance Company has the right to recover the Overpayment Amount through any means available by law, and (c) Co-operators Life Insurance Company will offset any benefits payable to me by the Overpayment Amount until Co-operators Life Insurance Company has recovered the Overpayment Amount in full.

Plan Member Signature _____ Date _____
MMM/DD/YYYY