



Your Dentist can submit this claim for you if you provide them with your all-in-one benefit card

## SHEET METAL WORKERS LOCAL 30 BENEFIT PLAN DENTAL CLAIM FORM

<b>PART 1 DENTIST</b>			UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFIT PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER.  SIGNATURE OF SUBSCRIBER _____
P A T I E N T	LAST NAME _____	GIVEN NAME _____	D E N T I S T		PHONE NO. _____	
I E N	ADDRESS _____	APT. _____				
T	CITY _____	PROV. _____				POSTAL CODE _____

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 RELEASE OF THE INFORMATION CONTAINED IN THIS FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT / GUARDIAN) \_\_\_\_\_

OFFICE VERIFICATION / DENTIST'S SIGNATURE \_\_\_\_\_

DUPLICATE FORM

DATE OF SERVICE			PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						

### INSTRUCTIONS

1. EMPLOYEE COMPLETES PART 2 AND PART 3.
  2. HAVE YOUR DENTIST COMPLETE PART 1.
  3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
  4. SEND THIS CLAIM TO: ADMINISTRATION OFFICE, 45 MCDINTOSH DRIVE MARKHAM, ONTARIO L3R 8C7 TELEPHONE: (905) 946-9700 FAX: (905) 946-2535 CANADA TOLL FREE: 1-800-263-3564
- Or Submit Claim Directly - Your Dentist can do this using the All In One Benefit Card**
- FOR QUESTIONS, CONTACT [INFO@LU30PLAN.COM](mailto:INFO@LU30PLAN.COM)

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

TOTAL FEE SUBMITTED \_\_\_\_\_

### PART 2 MEMBER IDENTIFICATION

MEMBER'S NAME \_\_\_\_\_ UNION IDENTIFICATION NUMBER \_\_\_\_\_

MOST RECENT EMPLOYER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

DAY                  MONTH                  YEAR

AUTHORIZATION AND SIGNATURE:

I certify that, if this claim is being made on behalf of my Spouse and/or Dependents, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I certify that the information given is true, correct and complete to the best of my knowledge. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

Please complete all of the above information. The claim will be returned if any information is missing.

SIGNATURE \_\_\_\_\_

### PART 3 MEMBER'S STATEMENT (please print)

1. PATIENT'S RELATIONSHIP TO MEMBER \_\_\_\_\_ 2. PATIENT'S DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU? YES  NO  DAY MONTH YEAR

3. A) ARE YOU OR ANY MEMBER OF YOUR FAMILY ENTITLED TO DENTAL BENEFITS FROM ANY OTHER PLAN? YES  NO

IF YES, GIVE NAME AND ADDRESS OF OTHER PLAN \_\_\_\_\_

NAME OF FAMILY MEMBER INSURED \_\_\_\_\_ POLICY # \_\_\_\_\_

B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? YES  NO

IF YES, NAME OF FAMILY MEMBER \_\_\_\_\_

C) IF YES TO A) OR B) ABOVE, AND THE PATIENT IS A DEPENDANT CHILD, PLEASE PROVIDE SPOUSE'S BIRTH DAY AND MONTH \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

DAY MONTH

6. IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES  NO  IF YES, GIVE DATE, LOCATION AND EXPLAIN HOW ACCIDENT HAPPENED \_\_\_\_\_

7. IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? YES  NO  IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT \_\_\_\_\_