



MAIL TO: Group Operation
400 – 200 Main Street, Winnipeg, MB R3C 1A8 1-800-665-7076

**Dental Claim Form
with Health Spending Account**

CLAIMING INSTRUCTIONS

1. This form is to be completed by the dental office (Part 1) and the employee (Part 2).
2. Assignment of Benefits is irrevocable.
3. Submission of diagnostic x-rays or sturdy models (if appropriate) for review by our dental consultant may prevent delays in the processing of your claim.

PART 1 – DENTIST

P A T I E N T	Last Name		Given Names		D E N T I S T	Unique No.	Spec.	Patient Account No.	FOR DENTIST USE ONLY FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION		
	Street Address										
	City	Prov.	Postal Code								

DATE OF SERVICE	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACE	DENTIST FEE	LAB CHARGE	TOTAL CHARGE	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE DENTIST
DAY	MO	YR					
							Signature of Subscriber I understand that the fees listed in this claim may not be covered by or may exceed my policy 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 claim form to my insuring company or its agents. Signature of Patient (or Parent Guardian) Office Verification

PART 2 – EMPLOYEE STATEMENT

Group No: **G** Employer Name: _____ Certificate No: **WLI**

Employee Name _____ Relationship to Patient _____

Home Address (Complete if this is your first claim or if your address has changed since your last claim.)
 _____ (Street) _____ (City) _____ (Prov) _____ (Postal Code)

1. Are you, your spouse or dependents eligible for the claimed expenses under any other plan? YES NO
 If YES, name of other carrier _____ Spouse's Name _____ Spouse's Date of Birth _____
 Effective Date of Coordination of Benefits(YY/MM/DD) _____ Termination Date of Coordination of Benefits(YY/MM/DD) _____
 (attach copy of statement of payment or denial from other carrier)
2. Is any treatment required as the result of an accident? YES NO
 If YES, please provide details on the reverse and advise if claim is being filed with Workers Compensation or auto insurer.
3. If denture or bridge, is this an initial placement? YES NO
 If YES, please provide dates of extractions _____
 If NO, please provide date of prior placement and reason for replacement _____
4. If crown or onlay, is this an initial placement? YES NO
 If NO, please provide date of prior placement and reason for replacement _____
5. Is any treatment required for Orthodontic purposes? YES NO

6. Apply excess expenses to my Health Spending Account? YES NO

PART 3 EMPLOYEE AUTHORIZATION

Notice Concerning Personal Information
 You have previously provided consent to Wawanesa Life for the collection, use and disclosure of your personal information for the purposes of: establishing and maintain communications with you; underwriting risks on a prudent basis; investigating and paying claims; detecting and preventing fraud; offering and providing products and services to meet your needs; compiling statistics and acting as required or authorized by law. That consent applied to personal information being provided to Wawanesa Life at that time and to personal information that may be provided after that time.

You can obtain further information about Wawanesa Life's Personal Information Protection Policy from the Wawanesa Life Head Office at 400 – 200 Main Street, Winnipeg, MB R3C 1A8 or at www.wawanesalife.com.

Authorization
 I have read the above Notice Concerning Personal Information. I authorize the release of any information in respect of this claim to Wawanesa Life. I further certify that the information on this form is true and complete.

 Employee Signature _____
 Date

For Wawanesa Life Head Office Use Only