DENTAL EXPENSE CLAIM FORM

SECTION 1 - TO BE COMPLETED BY DENTIST

PATIENT

Last name	First name	
Mailing address		
City	Province	Postal code

DENTIST

Unique No.	Spec.	Patient's office account no.
Phone number		

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

_____
Signature of plan member

For dentist's use only - For additional information, diagnosis, procedures, or special consideration.

Duplicate form ☐

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 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 claim form to my insurance company/plan administrator.

Signature of patient (Parent/Guardian) _____

Office verification / Dentist's signature _____

Date of service yyyy	mm	dd	Procedure code	Int. tooth code	Tooth surfaces or units	Dentist's 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

Return completed form to Coughlin for processing

COUGHLIN
employee benefits specialists

Tel: 204-942-4438 / 1-888-204-1234
Fax: 204-942-2741

Mailing address
PO Box 764
Winnipeg, MB R3C 2L4

SECTION 2 - TO BE COMPLETED BY PLAN MEMBER

Plan sponsor/Group name			Member ID/PIN	
Member last name	Member first name	Member middle initial	☐Male ☐Female	Date of birth (yyyy/mm/dd)
Mailing address		City	Province	Postal code
Email address	Primary telephone	Secondary telephone	Language of correspondence	☐English ☐French

PATIENT INFORMATION Complete only if claim is for a dependant (spouse or child)

Patient relationship to plan member	Date of birth (yyyy/mm/dd)	☐Male ☐Female	Full-time student ☐ Yes ☐ No	Disabled child ☐ Yes ☐ No

COORDINATION OF BENEFITS How to submit a claim when there are two (or more) benefits plans

Is the named patient entitled to benefits under any other plan for the expenses being claimed? ☐Yes ☐No
If yes, provide the following information:

- Who does the other plan belong to? ☐ Self ☐ Spouse ☐ Ex-spouse ☐Full-time student

First name	Last name	Date of birth (yyyy/mm/dd)
Name of insurance company	Plan number	Plan member ID number

If other coverage pertains to a dependant child, please provide spouse's (or ex-spouse's) date of birth (yyyy/mm/dd) _____

- If other coverage is also with Coughlin, do you want us to process the claim through both benefits plans? ☐Yes ☐No

- Send your claims to your own plan first. When you receive your explanation of benefits, send it along with copies of your receipts to the other plan to claim any unpaid amount.
- Send your spouse's claims to their plan first, then send a copy of their explanation of benefits and receipts to your plan.
- Send your dependant children's claims first to the plan of the parent whose birthday (month and day) occurs first in the calendar year.

Are any of the expenses associated with a work-related incident AND eligible for workers' compensation benefits? ☐Yes ☐No
If yes, submit these expenses to your provincial workers' compensation board.

CLAIM INFORMATION

1. Is this claim due to an accident? ☐ Yes ☐ No If yes, date of accident (yyyy/mm/dd) _____ Ensure to attach the details of the accident
2. Does the treatment involve the placement of a crown / bridge or denture? ☐ Yes ☐ No
   If yes, is this the initial placement? ☐ Yes ☐ No UPPER ☐ Yes ☐ No LOWER ☐ Yes ☐ No
   If no, provide the date of prior placement and attach an explanation (yyyy/mm/dd) _____

HEALTH CARE SPENDING ACCOUNT Complete only if you have this benefit

I confirm that I am eligible for a reimbursement of the indicated expenses under my Health Care Spending Account (HCSA). I understand that I must first submit my claim using the co-ordination of benefits with my spouse's plan, if applicable.

☐ I do not wish to use my HCSA ☐ I wish to use my HCSA to cover the expenses that are not reimbursed under my group insurance plan

CLAIM AUTHORIZATION & DECLARATION

I certify that:
(1) The information in this form is true and complete and does not contain a claim for an expense previously paid under any benefits plan.
(2) The goods and services being claimed have been received by the named patient.
(3) I am authorized to disclose the information about any other person identified on this form and to consent to the collection, use, and disclosure of their personal information as described below.
(4) The named patients authorize Coughlin & Associates Ltd. to disclose information about their claims to me for the purpose of assessing, investigating, and paying the claimed benefits, and managing my group benefits plan.
(5) If I am making a claim under my Health Care Spending Account, I certify that these expenses qualify for reimbursement.

I understand that:
(1) This claim may be audited and investigated.
(2) I may be contacted to obtain additional information, if required to process or investigate this claim.
(3) This claim may de declined and my coverage under my benefit plan may be terminated if this claim contains, or I subsequently provide false, incomplete, or misleading information.
(4) If any tax consequences arise from reimbursement of expenses under my Health Care Spending Account, I am responsible for payment of those taxes.

I agree that a photocopy or electronic copy of this form is as valid as the original.

AUTHORIZATION TO COLLECT, USE, AND DISCLOSE PERSONAL INFORMATION

When necessary for the purposes of administering, underwriting, adjudicating, managing, auditing, and investigating this claim, I authorize Coughlin & Associates Ltd., and its parent company, People Corporation to:

(1) collect and use the personal information provided on any form related to this claim.
(2) collect any additional personal information from any person or organization who has information relevant to this claim, such as health care providers and institutions, insurers, investigators, my employer or former employers, and benefit plan sponsor or trustees.
(3) disclose this personal information to any person or organization, such as health care providers, Coughlin & Associates Ltd.'s affiliated companies, insurance companies and their reinsurers, service providers, my employer or former employers, benefit plan sponsor or trustees, and investigators.

If there is a suspicion of fraud or benefit plan abuse related to this claim, or if I or a named patient have received an overpayment or otherwise obtained a benefit related to this claim to which we are not entitled, this personal information may be used and disclosed to other persons or organizations, including investigators, law enforcement, collection agencies, professional regulators, credit reporting services, the provider of the claimed product or service, and my employer, or the benefit plan sponsors or trustees for the purposes of preventing fraud or abuse, investigating the suspicion or recovering the amount of the overpayment or benefit. In addition to any other remedies available to Coughlin & Associates Ltd., if I or a named patient have received an overpayment or otherwise obtained a benefit related to this claim to which we are not entitled and have not reimbursed Coughlin & Associates Ltd., I authorize the recovery of the amount of the overpayment or benefit from any amount payable to me under my benefit plan.

I understand that any audit authorization is only valid for the duration of the benefit plan related to this claim. Otherwise, the authorization is valid as long as this claim is being processed and as long as I am receiving benefits related to this claim, or until I revoke my authorization in writing. I also understand that if I revoke this authorization this claim will not be processed and I will not be entitled to receive any further benefits related to this claim.

Member signature	Date (yyyy/mm/dd)

Protecting your personal information. We recognize and respect your right to privacy. When personal information is provided to us, we establish a confidential file that is kept in our facilities or in the facilities of an organization that we authorize. We limit access to information in your file to our personnel or other persons we authorize, who require the information to perform their duties with respect to the Plan, to persons to whom you have granted access, and to persons authorized by law. If you require more detail about how we protect your personal information or the other persons to whom we disclose your personal information, you may access our Privacy Policy at https://www.peoplecorporation.com/privacy/ or contact our privacy officer by mail sent to Coughlin & Associates Ltd., 1403 Kenaston Blvd., Winnipeg, MB, R3P 2T5, or by email sent to privacy.officer@peoplecorporation.com.