Saskatchewan
RWDSU DENTAL PLAN

P.O. Box 764, Winnipeg, Manitoba R3C 2L4
Telephone: 1-888-716-4422

STATEMENT OF CLAIM

MEMBER'S STATEMENT

This claim form must be completed each time an eligible expense is submitted for payment. A separate claim form is required for each member and each member's dependent for whom an expense has been incurred. Before commencing treatment where the estimated cost is $300 or more, please forward a pre-authorization form (i.e. estimate) to ensure the extent of applicable in advance.

Member's Name _____ Social Insurance Number _____

Address _____
(Street No. and Name) (City or Town) (Province) (Postal Code)

☐ Please check if your address has changed in the past 12 months

Name of Employer _____

Expense Incurred on Behalf of _____ Relationship _____ Date of Birth _____

If you are claiming for a dependent child who is age 18 or older please indicate if:

☐ Handicapped

☐ Student following a full time course of education _____
(Name of Educational Institution and Please provide copy of student card or registration receipt.)

Is your spouse a member of this Plan? Yes ☐ No ☐ If yes, Spouse's S.I.N. _____

Are any dental benefits provided under any other group insurance or dental plans? Yes ☐ No ☐
Having coverage through your spouse's plan will likely provide additional coverage. In order to coordinate benefits with your spouse's plan, please provide the following information:

If yes, Name of Family Member _____

Please provide Spouse's date of birth _____ | _____ | _____
Day Month Year

Plan Name or Insurer / Policy No. _____

Name and Address of Administrator _____

_____

Is claim made due to an accident?

☐ No

☐ Yes, If Yes, provide the following information:

Date of accident _____

How did accident happen? _____

Did it happen at work?

☐ No

☐ Yes, If Yes, please apply to Worker's Compensation Board for payment

Are you or is your dependent entitled to benefits under any other plan for dental services required as a result of an accident?

☐ No ☐ Yes. If Yes, please provide the following information:

Plan Name / Policy No. _____

Name and Address of Administrator _____

_____

I authorize the use of my Social Insurance Number as my membership number under the Group Insurance as an identifier in Coughlin's & Associates Ltd's database. This authorization is valid throughout the duration of the Plan. A photostat of this authorization is as valid as the original. I understand that the information contained in this form, once completed and submitted to Coughlin & Associates Ltd., will be used in the administration of the Plan and, as required by law, for income tax reporting, as well as for statistical analysis.
I certify that the information contained in this form is true and complete to the best of my knowledge.

Date _____ Member's Signature _____

Please TURN OVER - Both sides of this card must be completed.

DENTIST'S / DENTURIST'S STATEMENT

INSTRUCTIONS FOR CLAIM SUBMISSION

MEMBER: PLease complete the reverse side of this claim form before submitting.

DENTIST / DENTURIST: When submitting a pre-determination DO NOT ENTER DATES OF SERVICE.
PRE-TREATMENT PERIAPICAL X-RAYS must be submitted for crowns, bridgework, inlays, onlays and veneers.
Please submit a copy of the original lab bill after completion of treatment.

PATIENT

DENTIST / DENTURIST PHONE NO. UNIQUE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST / DENTURIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER.

Signature of Member

Date of Service DAY	MO.	YR.	INTL. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	DENTISTS / DENTURIST'S FEE	LABORATORY CHARGE	TOTAL CHARGE	FOR PLAN ADMINISTRATION USE ONLY COVERED AMOUNT BASIC	MAJOR	ORTHO

TOTAL FEE SUBMITTED

1) NUMBER OF X-RAYS SUBMITTED: _____

2) IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

If no, give date prior placement and reason for replacement _____

_____

If Partial Denture, indicate teeth being replaced _____

3) IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO

4) WERE ANY SERVICES PERFORMED IN HOSPITAL? ☐ YES ☐ NO

ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURE, OR COMPLICATIONS:

DENTIST'S / DENTURIST'S CERTIFICATION:

This Statement is:

☐ A pre-determination only

☐ An Accurate statement of services performed and fees charged E. & O.E.

DENTIST'S / DENTURIST'S SIGNATURE

I am a duly certified specialist in the field

of _____