

Dental Accident Claim (continued)

PART 3. EMPLOYEE'S STATEMENT

1. **Name of Employer** _____
2. Name and address of Employee _____
 _____ Employee's birthdate (YYYY/MM/DD) _____
3. Patient's relationship to Employee _____ Patient's birthdate (YYYY/MM/DD) _____
4. If your firm has a **Health Spending Account**, please apply the balance of this claim towards this benefit. No Yes
5. Are you or your dependents entitled to benefits under any other plan? No Yes If "Yes," family member insured _____
 Name of insuring company _____ Spouse's birthdate (YYYY/MM/DD) _____
6. Are any of the services provided as a result of an accident? No Yes
 If "Yes," provide the date and details of the accident. _____
7. Are you claiming for a dependent child who is age 21 or older? No Yes
 If the patient is a dependent child, the child: has a physical or mental disability
 is a student (school's name and location) _____
 _____ Dates of studies (YYYY/MM/DD) _____
8. If treatment is a denture, crown or bridge, is it an initial placement? No Yes
 If "No," provide the last placement date and reason for replacement. _____
9. Is any treatment required for orthodontic purposes? No Yes
10. Please provide date of accident _____ 20_____ at _____ a.m./p.m.
11. Location of accident _____
12. Was the accident work related? No Yes
13. Date of first treatment (YYYY/MM/DD) _____
14. Please provide details of accident _____

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. 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.

If this claim includes an amount under my Health Spending Account, I certify that the amount qualifies as a medical expense for income tax purposes. I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. Any copy of this authorization shall be as valid as the original.

Signature of Employee _____ **Date** _____

ALL THE INFORMATION YOU PROVIDE ON THIS FORM WILL BE TREATED AS CONFIDENTIAL.

**Please mail this completed form and your original receipts to
 Chambers of Commerce Group Insurance Plan, 1051 King Edward Street, Winnipeg, MB R3H 0R4
 Telephone 1-800-665-3365 • Fax 1-800-457-8410**

Insuring Company: Desjardins Insurance

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company

THIS PLAN DOES NOT COVER ANY CHARGES FOR THE COMPLETION OF A FORM.