THE LABOURERS' MULTI-LOCAL WELFARE TRUST FUND OF ONTARIO

STANDARD DENTAL CLAIM FORM

ADMINISTRATOR: GLOBAL BENEFITS

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

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

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

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 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 CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

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

FOR ADMINISTRATOR USE

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

TOTAL FEE SUBMITTED

claim is the result of an auto related accident, please file claim with your insurance company.

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1.
2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.

PART 2 — MEMBER

1. PLAN NO. Fund 8 LOCAL NO
   PRESENT EMPLOYER
2. NAME OF MEMBER
   ADDRESS OF MEMBER

☐ INITIAL CLAIM? SUBSEQUENT? ☐

TELEPHONE NUMBER: HOME BUS.

MEMBER'S DATE OF BIRTH: DAY MONTH YEAR

MEMBER'S SOCIAL INSURANCE NUMBER

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE
   DATE OF BIRTH: DAY MONTH YEAR
   PATIENT'S OCCUPATION
2. IF CLAIM IS FOR THE DEPENDENT CHILD, IS THAT CHILD
   HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐
   A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐
   ARE YOU ENTITLED TO AN INCOME TAX EXEMPTION FOR THIS DEPENDENT? ☐ YES NO ☐
   NAME AND ADDRESS OF DEPENDENT'S EMPLOYER
3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES? ☐ YES NO ☐ IF "YES", PROVIDE:
   POLICY NUMBER:
   NAME OF INSURER:
   SPOUSE'S NAME:
   SPOUSE'S DATE OF BIRTH: DAY MONTH
4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐
5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐
   GIVE DATE AND DETAILS
   C) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐
6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
   A) IS THIS THE INITIAL PLACEMENT?
   UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐
   B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT
   C) DATE OF EXTRACTIONS

I authorize Global Benefits to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Date / / Signature of Member Telephone Number ( )

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL (SEE OVER)

THE LABOURERS' MULTI-LOCAL WELFARE TRUST FUND OF ONTARIO

ADMINISTRATOR: GLOBAL BENEFITS

CLAIM INSTRUCTIONS

1. To avoid delays in processing your claim, be sure all statements on the reverse are answered in full and have your dentist complete the other side of this form.

2. Re predetermination: If your dentist recommends a course of treatment involving fees of $300.00 OR MORE, his treatment plan, with X-rays, must be forwarded to the Plan's Administrator for predetermination of benefits before treatment begins. The Administrator will then advise both you and your dentist what the Plan will pay and therefore what, if anything, you will have to pay out of your own pocket.

3. Send all correspondence, this claim form, etc. to the Administrator:

   Global Benefits
   88 St. Regis Crescent South
   Toronto, Ontario M3J 1Y8
   Telephone: (416) 635-6000 Fax: (416) 635-6464

PLEASE NOTE:

Your Policy contains a Coordination of Benefits Provision which may allow you to receive reimbursement from both plans up to a maximum amount equal to the amount charged on the claim. The provision also determines which Insurance Carrier will be designated as First Payor, and which will be designated as Second Payor. Generally speaking, any plan which covers an individual either as the insured employee, or in the case of children, as the dependent of the spouse with the earliest birth date (day and month) in the calendar year, is designated as the First Payor. All claims should be first submitted to the company who is the First Payor.

NOTES: