# THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

## DENTAL BENEFIT CLAIM FORM

### PART 1 DENTIST

**PATIENT**

LAST NAME _____ GIVEN NAME _____

ADDRESS _____ APT _____

CITY _____ PROV. _____ POSTAL CODE _____

**DENTIST**

NAME _____ UNIQUE ID _____

ADDRESS _____

PHONE NO. _____

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

_____
**SIGNATURE OF SUBSCRIBER**

FOR DENTIST'S USE ONLY.
*FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.*

I UNDERSTAND THAT THE FEES I 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 FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

_____
**SIGNATURE OF PATIENT (PARENT / GUARDIAN)**

DUPLICATE FORM ☐ _____
**OFFICE VERIFICATION / DENTIST'S SIGNATURE**

| DATE OF SERVICE DAY | MO | YR | PROCEDURE CODE | INTL TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | TOTAL FEE SUBMITTED | | | |

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

### COMPLETION INSTRUCTIONS

1. MEMBER COMPLETES PART 2 AND PART 3.
2. DENTIST COMPLETES PART 1.
3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
4. SEND THIS CLAIM TO:
   THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
   ADMINISTRATION OFFICE
   16214 - 118 AVENUE
   EDMONTON, ALBERTA T5V 1M6
   TELEPHONE: (780) 452-1331
5. **CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF SERVICE DATE.**

### PART 2 MEMBER IDENTIFICATION

_____ MEMBER'S NAME

_ _ _ MEMBER'S SOCIAL INSURANCE NUMBER

AUTHORIZATION AND SIGNATURE:
I certify that, 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. I certify that the information given is true, correct and complete to the best of my knowledge. I authorize the use of my Social Insurance Number for claim identification purposes only. I understand that this information will be protected pursuant to the relevant legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

**Please complete all of the above information. The claim will be returned if any information is missing.**

_____
**SIGNATURE OF SUBSCRIBER**

### PART 3 MEMBER'S STATEMENT (please print)

**1.** PATIENT'S RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐

**2.** PATIENT'S DATE OF BIRTH ___ / ___ / ___ (DAY / MONTH / YEAR)

**3.** IF THE PATIENT IS A SPOUSE/CHILD, DOES HE/SHE RESIDE WITH YOU? YES ☐ NO ☐

**4.** IF THE PATIENT IS A CHILD OVER 18, IS HE/SHE A FULL-TIME STUDENT? YES ☐ NO ☐

**5. A)** ARE YOU OR ANY MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS FROM ANY OTHER SOURCE? YES ☐ NO ☐

IF YES, NAME OF FAMILY MEMBER _____

OTHER INSURANCE COMPANY _____ POLICY # _____

**B)** IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS A MEMBER UNDER THIS PLAN? YES ☐ NO ☐

IF YES, NAME OF FAMILY MEMBER _____

**C)** IF YES TO **A)** OR **B)** ABOVE, AND THE PATIENT IS A DEPENDENT CHILD PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ___ / ___ / ___ (DAY / MONTH / YEAR)

**6.** IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ NO ☐ IF YES, GIVE DATE, LOCATION, AND EXPLAIN HOW ACCIDENT HAPPENED

_____

**7.** IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT

_____

THIS BENEFIT IS NOT INSURED. DENTAL BENEFITS ARE FUNDED SOLELY BY THE ASSETS OF THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND.