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Depending on your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

Policy no. Policyholder's name

Member's last name First name

Certificate no. Date of birth Sex: M F Language: E F

PART 1: DENTIST'S STATEMENT

Patient (Last and first name) _____ For dentist's use only to provide additional information, diagnosis, procedures, or special considerations: _____ Duplicate <input type="checkbox"/> Predetermination <input type="checkbox"/>	Dentist (Last and first name/Address/Phone no.) _____ _____ _____ I hereby assign my benefits payable from this claim to the specified dentist and authorize payment directly to him/her. _____ Signature of subscriber I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$_____ is accurate and has been charged to me for services rendered. Member's signature _____ Verification (Dentist) _____
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Treatment and services rendered to the patient

DATE OF SERVICE			PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEES	LABORATORY CHARGES	TOTAL CHARGES
Y	M	D						

Total fee submitted

NOTE - PLEASE INCLUDE THE X-RAYS TAKEN BEFORE THE TREATMENT

1. Tooth code of teeth damaged as a result of the accident: _____
2. Condition of teeth prior to the accident. (Were they sound natural teeth?) Give details: _____

3. If treatment cannot be given immediately, specify the dates and nature of future treatment(s), as well as the reason for the delay: _____

4. Additional information: _____

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that the said treatment was necessary as the result of an accident.

Dentist's signature _____ Date

