DENTAL CLAIM FORM

PART 1 - TO BE COMPLETED BY DENTIST

PATIENT

LAST NAME | FIRST NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

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

PHONE NUMBER

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

SIGNATURE OF PLAN MEMBER

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

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE 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 INSURANCE COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ☐

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DATE OF SERVICE Y	M	D	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES OR UNITS	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. Have your dentist complete part 1.
2. Complete all questions in part 2.
3. Send form to **Coughlin & Associates Ltd.**

COUGHLIN
employee benefits specialists

Mailing Address:
P.O. Box 764
Winnipeg, MB R3C 2L4

Street Address:
175 Hargrave Street,
Suite 100,
Winnipeg, MB R3C 3R8

Tel.:
local - (204) 942-4438
toll free - 1-888-204-1234

E-mail:
winnclaims@coughlin.ca

Fax: (204)-942-2741

PART 2 - TO BE COMPLETED BY PLAN MEMBER

GROUP OR EMPLOYER
Iron Workers L.U. 771 83269

PLAN MEMBER'S FULL NAME

PERSONAL IDENTIFICATION NUMBER (PI.N.)

PLAN MEMBER'S ADDRESS

APT.

CITY/PROVINCE | POSTAL CODE

TELEPHONE NUMBER | DATE OF BIRTH YEAR MONTH DAY

1. IS THIS CLAIM DUE TO AN ACCIDENT? YES ☐ NO ☐

DATE OF ACCIDENT

IF "YES" ATTACH DETAILS OF THE ACCIDENT.

2. IF TREATMENT INVOLVES THE PLACEMENT OF A CROWN / BRIDGE OR DENTURE.

IS THIS THE INITIAL PLACEMENT? UPPER YES ☐ NO ☐ LOWER YES ☐ NO ☐

IF "NO", GIVE THE DATE OF PRIOR PLACEMENT AND ATTACH AN EXPLANATION.

YEAR MONTH DAY DATE

HEALTHCARE SPENDING ACCOUNT - if applicable
The Plan has recently revised its procedures whereby any remaining Health or Dental benefit expenses not covered by the basic Plan (i.e. deductibles, claims that have exceeded an allowable maximum etc.) are now automatically applied to the extent of your Healthcare Spending Account, if any, unless you indicate otherwise below.
The exception would be an instances of co-ordination of benefits with your Spouse's plan.
☐ Do not apply remaining claims expenses automatically to my H.S.A.

Are any dental benefits or services provided under any other group insurance or dental plan, Worker's Compensation or government plan?

Yes ☐ No ☐

If **yes,** indicate member under other plan: If spouse indicate: Self ☐ Spouse ☐

Name DOB Year Month Day

Name of other insuring agency or plan

Policy No. P.I.N.

N.B. **For coordination of benefits,** children must claim under the plan of parent with the earlier day and month of birth in the calendar year.

COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT

DEPENDENT'S LAST NAME | FIRST NAME

DATE OF BIRTH Year Month Day | RELATIONSHIP TO PLAN MEMBER

If this claim is for a dependent child age 21 or over, what was the date the child last attended school on a full time basis? Year Month Day

Name of school

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. **I authorize** Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

PLAN MEMBER'S SIGNATURE

Protecting your personal information The administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefit plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

MEDICAL EXPENSE CLAIM FORM

Send all claims and inquiries to:

COUGHLIN
employee benefits specialists

Mailing Address:
P.O. Box 764
Winnipeg, MB R3C 2L4

Street Address:
175 Hargrave Street,
Suite 100,
Winnipeg, MB R3C 3R8

Tel.:
local - (204) 942-4438
toll free - 1-888-204-1234

E-mail Inquiries Only:
winnclaims@coughlin.ca

Plan Member - insured

Group or employer: Iron Workers L.U. 771 83269

Personal Identification No.

Plan Member's Full Name

Date of Birth (y m d)

Address

Language Preference ☐ English ☐ French

City | Province | Postal Code | Residence Telephone No. | Work Telephone No. ext.

Are any health benefits or services provided under any other group insurance or health plan, workers' compensation or government plan?

☐ NO ☐ YES

If YES, who is the member of this other plan? Name _____ Date of Birth (y m d) _____ Relationship to Plan Member _____

Name of other insuring agency or plan _____ Policy No. _____ Certificate No. _____

Dependants

Please complete this section if you are claiming an expense for a dependant.
For co-ordination of benefits, children must claim under the plan of the parent whose birthday occurs earlier in the calendar year.

	Last Name	First Name	Date of Birth (y m d)	Complete this section, if dependant is age 21 or over. Name of School	Current or most recent registration period
Spouse					
Child(ren) ☐ Daughter ☐ Son					
☐ Other (describe)					
☐ Daughter ☐ Son					
☐ Other (describe)					
☐ Daughter ☐ Son					
☐ Other (describe)					

☐ Drug Expenses

Attach original receipts containing the drug identification number (DIN) and name of the drug.

☐ Vision Care Expenses

Attach original itemized receipts.

Date of final payment (y m d)

Is this a new prescription? ☐ YES ☐ NO

If NOT, reason for replacement _____

Check One
☐ Single ☐ Bifocal
☐ Contact lenses ☐ Trifocal

Check One (if applicable)
☐ Occupational safety glasses
☐ Prescription sunglasses
☐ As a result of cataract surgery (attach physician's recommendation)

Cost of lens(es) $_____
Cost of frame(s) $_____
Dispensing fee $_____
Examination fee (if applicable) $_____
Other (please explain) $_____
Total charges $_____

☐ Other Expenses

Attach original itemized receipts. For equipment and appliance expenses, Coughlin & Associates Ltd. requires a written recommendation from the prescribing physician, including diagnosis, and a copy of the provincial plan statement of payment (if applicable).

Nature of expense	Date Incurred (y m d)	Recommended by: Physician's Name	Amount $

HEALTHCARE SPENDING ACCOUNT - if applicable

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I certify that the information given is true, correct and complete to the best of my knowledge.

Date (y m d) _____ Plan Member's Signature _____

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