THE IRONWORKERS LOCAL 764
BENEFIT TRUST FUND
GROUP DENTAL CLAIM FORM

PART 1 – DENTIST	UNIQUE NO.	PATIENT'S OFFICE ACCOUNT NO.	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.
PATIENT: Last Name Given Name Address Apt City Prov Postal Code	DENTIST PHONE NO.		_____ Signature of Subscriber

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION	I understand the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fees 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)*
DUPLICATE FORM o	OFFICE VERIFICATION / DENTIST'S SIGNATURE

Date of Service Day	Mo.	Yr	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SSURFACES	DENTIST FEE	LABORATORY CHARGE	TOTAL CHARGES

PLEASE SUBMIT CLAIM FORM TO:
Manion, Wilkins & Associates Ltd
626 - 21 Four Seasons Place
Etobicoke ON
M9B 0A6
1-800-263-5621 *(Toll Free)*
Plan Administrator Use Only

Policy Number: 00380000

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

PART 3 – EMPLOYEE complete this section *(please print)*

Member Name:	Certificate Number	Date of Birth Day Month Year
Member Address	City / Town	Prov / Postal Code

1. Do you or your dependent(s) have any other insurance to cover these benefits? ☐ Yes ☐ No If yes, please specify

Insurance Company Name	Policy Number	Certificate Number

2. If denture, bridge or crown, is this an Initial placement: ☐ Yes ☐ No	If initial placement, advise the date teeth were extracted and all other missing teeth. Date:	If replacement, advise date of prior placement and reason for replacement. Date:

3. If this claim is for a spouse or child, complete the following information:

Dependent's Date of Birth Day Month Year	Relationship to Employee ☐ Spouse ☐ Child	Is this dependent working? ☐ Yes ☐ No	Is this dependent attending school? ☐ Yes ☐ No	If yes, give name of employer or school

4. If treatment is due to an accident, indicate date of accident and details.

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that the Plan Administrator will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the Plan Administrator to evaluate or investigate my claims and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I hereby authorize my union, physician or other health professionals, any medical or dental facility, any insurance company or government body, and any other person or institutions to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Member's Signature	Date	Phone Number