THE CAMPUS TRUST

Mail To: TheCampusTrust
100-61International,Blvd
Toronto,ON,M9W6K4

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

PART 1 DENTIST

UNIQUE No | SPÉC | 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 Student

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 THE TOTAL FEE OF $_____ IS ACCURATE AND HAS BEEN CHARGE 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 D	M	Y	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charge	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

IMPORTANT

For costly dental work, you should submit your claim For predetermination of benefits so you will know in advance how much will be covered.

Predeterminations are not required for routine dental work and emergency treatment

You may be required to submit X-rays for crowns or bridge work. X-ray will be returned promptly to your dentist.

PART 2 STUDENT (*Complete this part before taking the form to your dentist's office*)

1. PATIENT: RELATIONSHIP TO STUDENT _____ DATE OF BIRTH _____
   IF CHILD, INDICATE ☐ FULL TIME STUDENT ☐ HANDICAPPED
   DATE ENROLLED _____ DATE COMPLETED _____

2. DO YOU HAVE ANOTHER PLAN THAT PROVIDES HEALTH OR DENTAL BENEFITS FOR YOU OR YOUR DEPENDENTS? ☐ NO ☐ YES
   ☐ HEALTH ONLY ☐ DENTAL ONLY ☐ BOTH
   IF YES, IS THE OTHER COVERAGE PROVIDED THROUGH ☐ SSQ FINANCIAL ☐ OTHER INSURER
   INDICATE POLICY NUMBER _____
   IF THIS CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

3. IS ANY TREATMENT REQUIRED AS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO
   GIVE DATE AND DETAILS

4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ YES ☐ NO
   IS ANY TREATMENT FOR TMJ PURPOSES? ☐ YES ☐ NO

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO
   IF INITIAL PLACEMENT ADVISE DATE TEETH WERE EXTRACTED _____
   AND ALL OTHER MISSING TEETH IN ARCH_____
   IF REPLACEMENT GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT

6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

7. HAVE YOU TERMINATED YOUR MEMBERSHIP WITH THE TRUST PROVIDING THESE DENTAL BENEFITS. IF SO, WHEN ____ / _____ / _____
   DAY MONTH YEAR

8. STUDENT I.D. _____
   STUDENT'S DATE OF BIRTH _____ /_____ / _____
   DAY MONTH YEAR

30W31

9. CONTRACT NO. _____
   CONTRACTHOLDER AND LOCATION

UPEI Student Union

10 AUTHORIZATION: On behalf of myself and my eligible dependents, I authorize the Trust and my group benefit provider, SSQ Financial and any of its affiliates or reinsurers to exchange the personal information contained on this form or any other benefit related personal information contained in their files now or in the future respecting me or any of my eligible dependents. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as I and my dependents are covered by, or are claiming benefits under the present group contract, or any modification, renewal or reinstatement thereof.

Student's Name: _____
(Please Print)

Address: _____

Date _____ Signature of Student _____ Telephone Number _____

Date _____ Signature of Spouse if claim is to be coordinated with another SSQ Financial Plan _____