Pensioners' Dental Services Plan (PDSP) Claim Form

Sun Life Financial

CANADIAN DENTAL ASSOCIATION / ASSOCIATION DENTAIRE CANADIENNE

Approved by the Canadian Dental Association

Clear

PROTECTED once completed

- The PDSP is administered by **Sun Life Assurance Company of Canada**
- Please provide complete information and print clearly
- If you are also a member of the Public Service Health Care Plan (PSHCP) and you wish us to coordinate the processing of dental claims covered under both plans:
  - for **oral surgery claims** complete and sign both a PDSP and a PSHCP claim form and mail them togethe to our Dental Claims Office (listed on the reverse)
  - for **accidental injury claims** complete and sign both a PSHCP and a PDSP claim form and mail them together to our Health Claims Office

1 To be completed by Dentist

PATIENT

Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

DENTIST

Unique Number | Spec. | Patient's Office Account No.

Phone No.:

I hereby assign my benefits 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.

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 that the total fee of $ is accurate and has been charged to me for services rendered. I authorize release of the information in this claim form to my insuring company / plan administrator. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of Patient (Parent/Guardian) _____

Office Verification/Dentist's Signature _____

Date of Service Day	Month	Year	Procedure Code	Intl Tooth Code	Tooth Surfaces	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

For Plan Administrator Use Only

2 To be completed by member

Member information

Contract number	Certificate number	Preferred language of correspondence
25555		☐ English ☐ French

Last name	First name	Date of birth (yyyy-mm-dd)	Telephone number
		_ _	_ _

Address (street number and name)	Apartment or suite	City	Province	Postal code

Family member covered by this claim

Spouse's last name	First name	Date of birth (yyyy-mm-dd)
		_ _

Unmarried child's name	Relationship to you	Date of birth (yyyy-mm-dd)	If child is 21 or over, check whether child is:
	☐ Son ☐ Daughter	_ _	☐ Disabled ☐ Full-time student

For SLF use:
DCF

3 Details of claim

1. Major restorative or prosthodontic caims (e.g. crowns, inlays, bridges, dentures, etc.)

Is this the initial placement? ☐ No ☐ Yes		
If no, date of prior placement (yyyy-mm-dd)	Reason for replacement	Date dentist took impression for this treatment (yyyy-mm-dd)
Please ask your dentist to incude the following to facilitate handling of your claim: • Pre-treatment x-rays (for crowns, inlays, onlays, veneers and bridges only)		

2. Are any expenses the result of an accident? ☐ No ☐ Yes If yes, complete the following:

When did the accident occur? (yyyy-mm-dd)	Where did the accident occur? ☐ Work ☐ Home ☐ Other	How did the accident occur?
Are any expenses the result of a condition covered by Workers' Compensation/Workplace Safety and Insurance Board? ☐ No ☐ Yes		

3. Orthodontics

Is this treatment for orthodontic purposes? ☐ No ☐ Yes	If yes, date initial appliance was installed (yyyy-mm-dd)

4 Coverage under other benefit plans

Are **you** covered for any of these expenses under any other benefit plan as an active employee?
☐ No ☒ Yes If yes, you must submit a claim to your employee plan **first**; then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.

Are **you** covered for any of these expenses under any other benefit plan as a pensioner?
☐ No ☒ Yes If yes, please indicate:

Name of insurer	Contract number	Certificate number

Is **your spouse, common law partner, or child** covered for any of these expenses under any other benefit plan?

☐ No ☐ Yes

If yes, spouse or common law partner's date of birth (yyyy-mm-dd)

If yes:
- You must submit a claim for your spouse or common law partner to their plan **first**.
- You must submit a claim for your child **first** under the plan of the parent with the earliest birthday (month and day) in the calendar year.
- Once the other plan processes the claim, then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.

5 Member certification and authorization

I certify that the statements in this claim are true and complete and do not contain a claim for any expenses previously paid for by this or any other plan. I also certify that my covered family members, if applicable, meet the plan eligibility requirements. I authorize release of any information or record requested in respect of this claim to the Plan Administrator, Sun Life Assurance Company of Canada to be used for the limited and sole purposes of underwriting, administering and paying claims under the PDSP. The Plan Administrator may check the accuracy of the information given in support of this claim.

Member signature X	Date (yyyy-mm-dd)

Mailing instructions

Mail the completed form to:

Sun Life Assurance Company of Canada
Dental Claims Office
PO Box 6159 STN-CV
Montreal QC H3C 3A7

613-247-5100 or
1-888-757-7427 (toll-free in North America)

For SLF use:
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