

Volunteer Accident Insurance: Dental Claim Form



Please answer all questions fully – it helps us to provide better service.

Important: If injury involves teeth, please complete this Student Accident Insurance: Dental form. If the Member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to this Dental plan. If there is any unpaid balance, please attach their Payment Statement(s). Please retain copies of receipts for your files, as originals will not be returned.

Note: This form must be completed in ink (please print), then signed and dated by ALL parties. The ORIGINAL, signed form in its entirety must be returned along with ORIGINAL medical receipts to:

AXA Assurances Inc.

2020 University Street, Suite 700

Montreal, Quebec H3A 2A5

1-800-561-7251 (ext 4472 or 4473)

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Patient Information

Policy Number: 9700002

1. Insured person's full name _____ 2. Date of Birth D M Y
3. If injured person is a minor, give full name of parent or guardian _____
Address _____
Street _____ City _____ Province _____ Postal Code _____
4. Is the injured person a Canadian Resident? Yes No Handicapped 5. Telephone No. () _____
6. What was the date of the accident? D M Y _____ Time of accident? _____ am pm
7. Where did accident occur? _____
8. Nature of injury _____
9. Describe fully how accident occurred _____

10. Full name of Dentist _____ Date of first treatment D M Y
11. Name of hospital if treated in hospital _____
Date admitted D M Y _____ Time _____ am pm
Date discharged D M Y _____ Time _____ am pm

School Declaration (to be completed by the School Administrator)

1. Name of School Board _____
2. Name of School _____
3. Complete Address _____
Street _____ City _____ Province _____ Postal Code _____
4. Effective date of volunteer coverage D 01 _____ M 04 _____ Y 2011 ____ . by signing this school declaration you are declaring that this person is a registered volunteer* of the school. **Registered volunteers--police and child abuse registry checks must have been done and be held at the school on file and approved by the school principal.*
5. School Official Signature _____ Print Name _____ Official's Position/Title _____
 D _____ M _____ Y _____
Telephone _____ Date _____

Employee / Plan Member / Subscriber (to be completed if there is coverage under another plan)

Member's Name _____ Date of Birth D _____ M _____ Y _____

Group Policy / Plan Number _____ Division Section Number _____

Employer _____

Name of insuring agency or plan _____

Patient Name _____ Relationship to Employee / Plan Member / Subscriber _____

Do you have coverage for dental expenses under any of the following:

Group Health Plan? Yes No Plan Name / Policy No. _____

Group Dental Plan? Yes No Plan Name / Policy No. _____

W.C.B. Plan? Yes No Plan Name / Policy No. _____

Government Plan? Yes No Plan Name / Policy No. _____

I certify to the best of my knowledge that the statements made above are true, correct and complete and I authorize AXA Assurances Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for AXA Assurances Inc.

For the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by AXA Assurances Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at AXA Assurances Inc. offices. Within AXA Assurances Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

**Privacy Officer
AXA Assurances Inc.
2020, University Street, Suite 700
Montréal, Québec H3A 2A5**

This consent shall be valid for the length of time necessary for AXA Assurances Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving AXA Assurances Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in AXA Assurances Inc. being unable to provide me with a product or service. A copy of this consent shall be considered as effective and valid as the original.

Insured person's signature (or signature of parent or guardian if injured person is a minor)

() _____
Telephone

D _____ M _____ Y _____
Date

Attending Dentist Statement

Unique No. _____ Spec. _____ Patient's Office Account No. _____

Dentist's Name: Address: Phone No. ()	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of patient (parent / guardian)	For Dentist use only <input type="checkbox"/> Duplicate form (for additional information, diagnosis, procedures or special consideration)
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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 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 Charges	Total Charges	For Carrier Use:				
							Allowed Amt.	Inc.	%	Patient's Share	
This is an accurate statement of services performed and the total fee due and payable, E & OE.							Total Fee Submitted: \$ _____	Claim Number _____			

Dentist's Supplementary Report

1. Description of damage _____

2. Is further treatment indicated? Yes No If "Yes", please indicate:

Intl. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

3. Describe further potential problems and indicate time frame _____

4. A) How many teeth were injured? _____ B) Were these whole or sound teeth? Yes No C) How many of these teeth had fillings? _____
 D) How many of these injured teeth had crowns? _____ E) How many of these injured teeth had root canal treatment? _____
 F) If not whole or sound teeth, explain reason why _____

Dentist's Signature _____ Date