



SIR SANDFORD FLEMING COLLEGE

PART 1 – DENTIST				UNIQUE NO. ☐ SPEC. ☐ 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 _____ SIGNATURE OF SUBSCRIBER				
P A T I E N T D E N T I S T PHONE NO.												
				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 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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST AND THE PLAN MEMBER. _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)				
DUPLICATE FORM ☐				OFFICE VERIFICATION/DENTIST'S SIGNATURE								
DATE OF SERVICE			PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE			
DAY	MO.	YR.							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE
									CHEQUE NO.		DATE	
									DEDUCTIBLE		PATIENT PAYS	
											PLAN PAYS	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.					TOTAL FEE SUBMITTED				CLAIM NO.			

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO. **515647** DIVISION / SECTION NO. _____ 2. YOUR NAME (PLEASE PRINT) _____
INSTITUTION **SIR SANDFORD FLEMING COLLEGE** **STUDENT IDENTIFICATION NUMBER** **00** **F**
NAME OF INSURING AGENCY OR PLAN **ClaimSecure/IAP** YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 – PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____
DATE OF BIRTH _____ DAY MONTH YEAR
IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐
IF STUDENT, INDICATE SCHOOL _____
PATIENT I.D. NO. _____
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN ☐ NO ☐ YES
POLICY NO. _____ SPOUSE DATE OF BIRTH _____
NAME OF OTHER INSURING AGENCY OR PLAN _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS ☐ NO ☐ YES
4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ☐ NO ☐ YES
5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES
6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE
DATE _____ DAY MONTH YEAR
SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER _____

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)

1. DATE COVERAGE COMMENCED	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR	AUTHORIZED SIGNATURE
2. DATE DEPENDENT COVERED								
3. DATE TERMINATION (OR TITLE)								

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER.