UNITE HERE HEALTH & WELFARE PLAN

Administered by
SOBEN LTD.
150 Consumers Rd., Ste 302
Toronto, Ont. M2J 1P9
Tel: (416) 498-8338 • Toll Free: 1-888-887-6879 • Fax: (416) 498-4591

DENTAL PLAN CLAIM FORM

INSTRUCTIONS TO MEMBER

1. Complete the Employee's statement (below) on each form sent in.
2. Have the attending Dentist complete and sign statement on back.
3. All correspondence, claim forms etc.... should be mailed to:

   Soben Ltd.
   150 Consumers Rd., Ste 302
   Toronto, Ont. M2J 1P9
4. Your Social Insurance Number
5. Your place of employment _____
6. Telephone Numbers: Home: _____ Business _____

MEMBER'S STATEMENT

N.B. Any recommended course of treatment involving fees of $500 or more must be submitted along with x-ray's to the administrator for insurer approval before a claim can be made.

1. Name of insured	Address (give number, street, city & prov.) Postal Code	2. Date of birth Day / Month / Year	Date of employment Day / Month / Year

3. Name of patient	Relationship to insured	Date of birth	Occupation

4. If child age 21 or over, indicate: ☐ Student ☐ Handicapped
   If student, furnish proof of school registration.

5. Is any treatment for orthodontic purposes? ☐ no ☐ yes

6. If denture crown or bridge, is this initial placement? ☐ no ☐ yes
   Give date of prior placement and reason for replacement:

7. Is this dental care covered by another group insurance or dental care plan? ☐ no ☐ yes

   Policy number: Certificate number:

   Name of insurance company:
   Covered as ☐ insured ☐ dependent

   If dependent, name of the insured:

8. Is treatment required due to an accident? ☐ no ☐ yes

   Indicate date and specify:

9. Is claim being made for workmen's compensation? ☐ no ☐ yes

10. I hereby certify that the above information is true and that these expenses were incurred for the exclusive use of the person(s) named above. I authorize any medical practitioner, hospital, employer, UNITE HERE Ontario Council, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare Plan and Pension Plan and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

    Date: _____ Signature: _____

SMO2-B

DENTIST'S STATEMENT

DENTIST		PATIENT	
NAME		PATIENT'S LAST NAME	GIVEN NAMES
ADDRESS		ADDRESS	APT.
CITY, PROV.		CITY	PROV.
POSTAL CODE	N.I.S. OR U.I.N.	POSTAL CODE	
TELEPHONE			

FOR PLAN ADMINISTRATOR USE ONLY

DATE OF SERVICE			INT. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL CHARGE	ELIGIBLE AMOUNT
DAY	MO.	YR.							

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED, E & OE.

TOTAL SUBMITTED FEE ➡

DATE:

FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURES, OR COMPLICATIONS AND TIME IN UNITS

TOTAL

PAYMENT

APPROVALS

PLEASE COMPLETE DATES OF TREATMENT BEFORE RETURNING DENTAL CLAIM FOR PAYMENT.

ALL APPROVALS SUBJECT TO DEDUCTIBLE & THE PATIENTS CONTINUOUS DENTAL INSURANCE COVERAGE.

APPROVED

DATE

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY OR ITS AGENTS.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

ALL PAYMENTS WILL BE PAID DIRECTLY TO THE MEMBER

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL