UNITE HERE HEALTH & WELFARE PLAN

Administered by SOBEN LTD. Consumers Rd., Ste 302

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 FO	PRM					
	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:						
INSTRUCTIONS TO MEMBER	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 approval before a claim	course of treatment involving fees of \$500 or more must be submitte can be made.	ed along with x-ray's to the administrator for insurer					
I. Name of insured	Address (give number, street, city & prov.) Postal Code	2. Date of birth Day / Month / Year Date of employment Day / Month / Year	/ea				

	MEM	BER'S STATEMENT				
N.B. Any recommended course approval before a claim can be	e of treatment involving fees of \$500 e made.	or more must be submitted alor	ng with x-ray's to	the adminis	strator for insurer	
1. Name of insured	ddress (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: If student, furnish proof of school	5. Is any treatment for	5. Is any treatment for orthodontic purposes? ☐ no ☐ yes				
6. If denture crown or bridge, is this Give date of prior placement and	s initial placement? ☐ no ☐ yes d reason for replacement:					
	nother group insurance or dental care pl				er act glob, reges	
(a						
Covered as ☐ insured ☐ dep						
If dependent, name of the insure	d:					
8. Is treatment required due to an a		and the second section of the section of the second section of the section of the second section of the section of th		1911 T. S		
Indicate date and specify:						
9. Is claim being made for workmen		ALEPSKE ON A COT				
employer, UNITE HERE Ontario Cou	nation is true and that these expenses were in uncil, drug card provider and insurance compa Health & Welfare Plan and Pension Plan and t ninistering the benefit plans.	any to release to the UNITE HERE Healt	h & Welfare Plan and	d its agents any	y information relevant to this	

Signature:

DENTIST'S STATEMENT PATIENT'S LAST NAME GIVEN NAMES NAME E **ADDRESS** ADDRESS APT. N CITY, PROV. T CITY PROV. POSTAL CODE N.I.S. OR U.I.N. S POSTAL CODE T TELEPHONE FOR PLAN ADMINISTRATOR USE ONLY DATE OF SERVICE PROCEDURE LABORATORY CHARGE TOOTH DENTIST'S TOTAL ELIGIBLE DAY MO. YR. OR LAZ A D M INISTRATOR SE 02 THIS IS AN ACCURATE STATEMENT OF SERVICES TOTAL SUBMITTED PERFORMED AND FEES CHARGED, E & OE. TOTAL **APPROVALS** PLEASE COMPLETE DATE: DATES OF TREATMENT FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURES, OR COMPLICATIONS AND TIME IN UNITS BEFORE RETURNING DENTAL CLAIM FOR PAYMENT.

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.

ALL PAYMENTS WILL BE PAID DIRECTLY TO THE MEMBER

PAYMENT

INSURANCE COVERAGE.

APPROVED

DATE

ALL APPROVALS SUBJECT TO DEDUCTIBLE & THE PATIENTS CONTINUOUS DENTAL

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL