PENSIONERS' DENTAL SERVICES PLAN

Dental Claims Incurred Outside of Canada

PROTECTED "B" WHEN COMPLETED

THIS IS A: ☐ Claim ☐ Treatment plan or estimate

Part 1 – Instructions

Please use this form to submit your claim or treatment plan for dental benefits coverage to Canada Life.

1. Have your dental provider complete Part 2.
2. Complete Parts 3 to 8 in full.
3. Send this form to the appropriate Canada Life address. See Part 9.

All claims under the Pensioners' Dental Services Plan (PDSP) must be submitted through you. We may disclose personal information about claims with your employer, your service provider and/or a person acting on your behalf when necessary to confirm eligibility and to mutually manage the claim.

Part 2 – Dental provider

PATIENT

FIRST NAME	LAST NAME		
ADDRESS		APT.	
CITY	PROV./TERR./COUNTRY	POSTAL CODE	

UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.

PROVIDER

PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED PROVIDER AND AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER.

SIGNATURE OF PLAN MEMBER

FOR PROVIDER'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 DENTAL BENEFITS COVERAGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY PROVIDER 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 OR GUARDIAN)

OFFICE VERIFICATION OR PROVIDER'S SIGNATURE

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTAL FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.

TOTAL FEE SUBMITTED

Part 3 – Plan member information - You must complete this section fully. If you are unsure of your plan or certificate number, please see your PDSP benefit card, the Canada Life PDSP Member Services website or Part 9 for our contact information.

Plan name	Plan number	Plan member's certificate number
Pensioners' Dental Services Plan		

Plan member's name

First name	Last name

Plan member's address

Number and street	City or town	Province/Territory/State	Postal/Zip Code

Country	**Date of birth**	Day	Month	Year

canada life™

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Part 4 – Patient information - Complete for all expenses; one line per patient.

Patient's name		Patient's relationship to plan member			Patient's date of birth			If the eligible dependant child is between 21 and 25 years old, are they a full-time student?	
First name	Last name	Self	Spouse or common-law partner	Eligible dependant child	Day	Month	Year	Yes	No
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐
		☐	☐	☐				☐	☐

Part 5 – Coordination of benefits - Complete this section to indicate whether the patient has dental benefits coverage under any other plan.

1. Is the patient entitled to any other dental insurance for the expenses being claimed? ☐ Yes ☐ No

   If yes, please answer the questions below.

2. Who does the other insurance plan belong to? ☐ Self ☐ Spouse or common-law partner ☐ Eligible dependant child

   First name _____ Last name _____

3. If the other insurance plan belongs to your spouse or common-law partner and the patient is an eligible dependant child, please provide your spouse or common-law partner's date of birth. Day _____ Month _____

4. Is the other insurance plan also with Canada Life? ☐ Yes ☐ No

   If yes, please provide: Plan number _____ Certificate number _____

   Other insurance plan member's signature of authorization: X _____

* If other insurance is not with Canada Life and you have submitted these expenses to your other insurer, please attach to this claim the explanation of benefits (EOB) provided by the other insurer. An EOB is required even if no benefits were paid by other insurance.

** We assess claims using the information you provided during positive enrolment. Any discrepancies may delay our assessment of your claim.

Part 6 – Information about your claim - Complete this section to provide us with additional information about your claim.

1. (a) Is this treatment required as the result of an accident? ☐ Yes ☐ No

   (b) If yes, please provide the date Day _____ Month _____ Year _____ Location _____

   How or type of injury _____

   (c) If covered under the Public Service Health Care Plan (PSHCP) provide a copy of the explanation of benefits.

2. (a) Is this claim for a denture, crown or bridge? ☐ Yes ☐ No

   (b) Is this the initial placement? ☐ Yes ☐ No

   (c) If yes, please provide pre-treatment x-rays for a crown or bridge.

   (d) If no, please provide the date of the prior placement Day _____ Month _____ Year _____

   and the reason for replacement. _____

3. (a) Is this treatment required for orthodontic purposes? ☐ Yes ☐ No

   (b) If yes, please provide the date the initial appliance was installed. Day _____ Month _____ Year _____

4 For services rendered in the USA only: Please select the currency in which you would like to be reimbursed.

   ☐ Canadian funds ☐ US funds (by cheque)

   Note: For claims incurred in all other countries, funds will be reimbursed in Canadian currency.

Part 7 – Privacy

At Canada Life, we recognize and respect the importance of privacy. Personal information we collect will be used to assess your claim and administer the group benefits plan. Please refer to the PDSP Privacy Statement (https:/www.canada.ca/en/treasury-board-secretariat/topics/benefit-plans/plans/pensioner-dental-services-plan/resources/pensioners-dental-services-plan-privacy-statement.html) for further information on how your privacy is protected. Where there is a difference between the Privacy Act (///laws-lois.justice.gc.ca/eng/acts/P-21/) and the PDSP Privacy Statement and Canada Life's Privacy guidelines, Canada Life will apply the most stringent requirements. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to canadalife.com.

Part 8 – Confirmation, Authorization and Signature

I authorize Canada Life, any healthcare or dentalcare provider, my plan sponsor, the Federal PSHCP Administration Authority (for the PSHCP only), Dental Board/Boards of Management (for the PSDCP and/or PDSP - whichever plans you are enrolled in with Canada Life), other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

In accordance with the Positive Enrolment Authorization and Declaration (welcome.canadalife.com/pdsp/review-authorizations-and-declarations.html) accepted during the completion of Positive Enrolment (refer to your Positive Enrolment Record if you completed Positive Enrolment by paper), I agree to the collection, use and disclosure of personal information as set out in the Privacy section, Canada Life's Privacy guidelines and the PSHCP, PSDCP and/or PDSP Privacy Statement(s) (whichever plans you are enrolled in with Canada Life).

For the purposes of appeals, audits, or in the case of overpayments and/or erroneous payments which I have not reimbursed to Canada Life, I agree that Canada Life may disclose personal information related to such payment to the Plan Sponsor, the Treasury Board of Canada Secretariat, and the Federal PSHCP Administration Authority (for the PSHCP only), Dental Board/Boards of Management (for the PSDCP and/or PDSP - whichever plans you are enrolled in with Canada Life). The Plan Sponsor/Treasury Board of Canada Secretariat may disclose this personal information to government institutions so that the overpayments and/or erroneous payments and associated interest (if applicable) can be deducted or set-off from any money due or payable to me by His Majesty. I certify that the information given on this claim form is true, correct and complete to the best of my knowledge.

I certify that all goods and services being claimed have been received by me, my spouse, common-law partner and/or my dependants; and that my spouse, common-law partner and/or dependants are eligible under the terms of my plan. The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

Plan member's signature X _____ **Date** Day | Month | Year

Part 9 – Submitting your claim

Please send your claim to Canada Life:

ONLINE

canadalife.com/pdsp

Sign in to your account through the PDSP Member Services website to submit claims or estimates.

MAIL

Winnipeg Benefit Payments
PO Box 6025 Station Main
Winnipeg MB R3C 3C7

Questions? Call Canada Life:

North America (toll-free): 1-855-415-4414
International (collect): 1-431-489-4064

Deaf or hard of hearing and require access to a telecommunications relay service?
Please contact us:
TTY to Voice: 711 • Voice to TTY: 1-800-855-0511

HAVE YOU COMPLETED ALL SECTIONS OF THIS CLAIM FORM?

Clear