Pensioners' Dental Services Plan (PDSP) Claim Form

PROTECTED once completed

- The PDSP is administered by **Sun Life Assurance Company of Canada**
- Please provide complete information and print clearly
- If you are also a member of the Public Service Health Care Plan (PSHCP) and you wish us to coordinate the processing of dental claims covered under both plans:
  - ➢ for **oral surgery claims** complete and sign both a PDSP and a PSHCP claim form and mail them together to our Dental Claims Office (listed on the reverse)
  - ➢ for **accidental injury claims** complete and sign both a PSHCP and a PDSP claim form and mail them together to our Health Claims Office

Approved by the Canadian Dental Association / L'Association dentaire canadienne

Part 1: To be completed by Dentist

Unique Number | Spec. | Patient's Office Account No.

PATIENT
Last Name | Given Name
Address | Apt.
City | Prov. | Postal Code

DENTIST

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of Subscriber

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 in this claim form to my insuring company/plan administrator.

Signature of Patient (Parent/Guardian)

Office Verification/Dentist's Signature

Duplicate Form ☐

Date of Service Day	Month	Year	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable E & OE

TOTAL FEE SUBMITTED

For Plan Administrator Use Only

Part 2: To be completed by Member

Member Information

Contract Number **25555** | Certificate Number | Date of Birth Day / Month / Year

Last Name | Given Name | Language of Preference ☐ English ☐ Français

Street Address | Apt. Number | Telephone No. ( )

City | Province | Postal Code | Country

Family Member Covered by this Claim

Full Name of Spouse or Common Law Partner | Date of Birth Day / Month / Year

Name of Unmarried Child	Relationship to you Son	Daughter	Date of Birth Day	Month	Year	If child is 21 or over, check whether child is: Disabled	Full-time Student
	☐	☐				☐	☐

continued on reverse ▶

Details of Claim

1. Major restorative or prosthodontic claims (e.g. crowns, inlays, bridges, dentures, etc.)

Is this the initial placement? No ☐ Yes ☐

If No,
- Date of prior placement: _____ / _____ / _____ (Day / Month / Year)
- Reason for replacement: _____

Date dentist took impression for this treatment: _____ / _____ / _____ (Day / Month / Year)

Please ask your dentist to include the following to facilitate handling of your claim:
- Pre-treatment x-rays (for crowns, inlays, onlays, veneers and bridges only).

2. Are any expenses the result of an accident? No ☐ Yes ☐ If yes, complete the following:

When and where did the accident occur? Day / Month / Year _____ / _____ / _____ Work ☐ Home ☐ Other ☐

How did the accident occur?

Are any expenses the result of a condition covered by Workers' Compensation/Workplace Safety and Insurance Board? No ☐ Yes ☐

3. Orthodontics

Is this treatment for orthodontic purposes? No ☐ Yes ☐ Date initial appliance was installed: _____ / _____ / _____ (Day / Month / Year)

Coverage Under Other Benefit Plans

Are **you** covered for any of these expenses under any other benefit plan as an active employee?

No ☐ Yes ☐ If yes: You must submit a claim to your employee plan **first;** then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.

Are **you** covered for any of these expenses under any other benefit plan as a pensioner?

No ☐ Yes ☐ Please indicate: Name of Insurer: _____

Contract Number: _____ Certificate Number: _____

Is **your spouse, common law partner, or child** covered for any of these expenses under any other benefit plan?

No ☐ Yes ☐ Spouse or common law partner's date of birth: _____ / _____ / _____ (Day / Month / Year)

If yes:
- You must submit a claim for your spouse or common law partner to their plan **first.**
- You must submit a claim for your child **first** under the plan of the parent with the earliest birthday (month and day) in the calendar year.
- Once the other plan processes the claim, then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.

Member Certification & Authorization

I certify that the statements in this claim are true and complete and do not contain a claim for any expenses previously paid for by this or any other plan. I also certify that my covered family members, if applicable, meet the plan eligibility requirements. I authorize release of any information or record requested in respect of this claim to the Plan Administrator, Sun Life Assurance Company of Canada to be used for the limited and sole purposes of underwriting, administering and paying claims under the PDSP. The Plan Administrator may check the accuracy of the information given in support of this claim.

Member Signature

X

Date Day / Month / Year

Mail the completed form to:

Sun Life Assurance Company of Canada
Dental Claims Office
PO Box 6159 STN CV
Montreal QC H3C 3A7

(613) 247-5100 or
1-888-757-7427 (toll-free in North America)