Plan Administration Office Address
45 McIntosh Drive
Markham, ON L3R 8C7
Phone: 1-800-668-7547 Fax: 1-905-946-2535
E-Mail: dental@boilermakersbenefits.ca

Submit Claim Directly
Your Dentist Can Do This Using The All In One Benefit Card

DENTAL – CLAIM FORM

BOILERMAKERS' NATIONAL HEALTH AND WELFARE PLAN (CANADA)

All Claims must be submitted within 12 months of the date of service. The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

PART 1: PROVIDER

UNIQUE NO.	SPEC.	PATIENT'S ACCOUNT NO.

PATIENT LAST NAME AND FIRST NAME

PATIENT STREET ADDRESS

CITY/PROVINCE/POSTAL CODE

PROVIDER

PHONE NO. _____

I HEREBY ASSIGN BY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED PROVIDER AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

_____
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 PLAN BENEFITS. 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 PLAN ADMINISTRATOR.

_____ _____
OFFICE VERIFICATION/DENTIST'S SIGNATURE **SIGNATURE OF PATIENT (PARENT/GUARDIAN)**

DATE OF SERVICE D	M	YR	PROCEDURE CODE	INTL TOOTH CODE		TOOTH SURFACES	DENTIST'S FEES	LAB CHARGES	TOTAL CHARGES
									0
									0
									0
									0
									0
									0
									0
									0

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

TOTAL FEE SUBMITTED: $ 0.00

INSTRUCTIONS

1. **MEMBER COMPLETE PART 2 AND PART 3.**
2. **DENTIST COMPLETE PART 1.**
3. **IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO YOUR DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.**
4. **SEND THIS CLAIM TO: BOILERMAKERS' NATIONAL BENEFIT FUNDS (CANADA) ADMINISTRATION OFFICE**

ADDRESS: 45 MCINTOSH DRIVE MARKHAM, ON L3R 8C7
FAX NUMBER: 1-905-946-2535
E-MAIL: DENTAL@BOILERMAKERSBENEFITS.CA

PART 2: MEMBER IDENTIFICATION

MEMBER'S NAME:

MEMBER'S SOCIAL INSURANCE NUMBER:

BOILERMAKERS' BENEFIT CARD ID NUMBER:

AUTHORIZATION AND SIGNATURE

I certify that, if this claim is being made on behalf of my Spouse and/or Dependants, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I certify that the information given is true, correct and complete to the best of my knowledge. I authorize the use of my Social Insurance Number for claim identification purposes only. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any persons or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

Please complete all of the above information. The claim will be returned if any information is missing. SIGNATURE_____

PART 3: MEMBER'S STATEMENT

PATIENT'S RELATIONSHIP TO THE PLAN MEMBER:

PATIENT'S DATE OF BIRTH (DD/MM/YEAR)

IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU?
YES ☐ **NO** ☐

IF THE PATIENT IS A CHILD OVER 21:
A) IS HE/SHE A FULL TIME STUDENT? YES ☐ **NO** ☐ If "YES", name of school: _____
B) IS HE/SHE EMPLOYED? YES ☐ **NO** ☐

A) ARE YOU OR ANY MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS FROM ANY OTHER SOURCE? YES ☐ **NO** ☐
If "YES", give Name and Address of other source: _____
Name of Family Member Insured: _____ Policy Number: _____

B) IS ANY MEMBER OF YOUR IMMEDIATE FAMILY (OTHER THAN YOURSELF) INSURED AS A MEMBER OF THE BOILERMAKERS'? YES ☐ **NO** ☐
If "YES", Name of Family Member: _____

IF "YES" TO A) AND B) ABOVE, AND THE PATIENT IS A DEPENDANT CHILD, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH _____

IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ **NO** ☐
If "YES", give Date, Location and explain how the accident happened: _____

IF CLAIM IS FOR A DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? YES ☐ **NO** ☐
If "NO", give Date of prior placement and reason for the replacement: _____

Privacy Statement: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal information will be protected pursuant to applicable legislation. The Plan may use and exchange information with relevant persons or organizations (health professionals, institutions, investigative agencies, unions, regulators, legal counsel, actuaries etc.) in order to manage the Plan and your entitlement to the Benefits of the Plan.
Questions related to the Privacy Policy of the Plan should be direct to the Plan Administration Office at 1-800-668-7547

Rev Date: 11/03/2014