Alexander Forbes Risk Services Limited
C/O THE NORFOLK GROUP
Suite 510, 940 6 Avenue SW, Calgary, AB, Canada, T2P 3T1

Standard Dental Claim Form

PART 1 DENTIST

UNIQUE NO	SPEC	PATIENT'S OFFICE ACCOUNT NO	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER
			SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV POSTAL CODE

DENTIST

PHONE NO

FOR DENTIST'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 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 CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION (DENTIST'S SIGNATURE)

DATE OF SERVICE DAY MO YR	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

FOR NORFOLK USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

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

TOTAL FEE SUBMITTED

CLAIM NO.

INSTRUCTIONS FOR CLAIM SUBMISSION

EMPLOYEE

1. FULLY COMPLETE ALL QUESTIONS IN PART 2, EMPLOYEE'S STATEMENT AND PART 3 PATIENT INFORMATION.
2. HAVE PART 1, DENTIST'S STATEMENT COMPLETED AND RETURNED TO YOU.
3. RETURN FORM TO THE NORFOLK GROUP

IMPORTANT INFORMATION

PRE-TREATMENT PLAN: IF YOUR DENTIST HAS RECOMMENDED CROWNS AND/OR BRIDGEWORK, OR ANY OTHER DENTAL EXPENSE OVER $500.00 (PER PATIENT) PLEASE HAVE YOUR DENTIST COMPLETE A PRE-TREATMENT PLAN AND SUBMIT IT TO THE NORFOLK GROUP BEFORE TREATMENT BEGINS.

PART 2 – EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. POLICY: **AM003842**
   Certificate Number:

2. YOUR NAME (PLEASE PRINT) _____
   LAST FIRST INITIAL

YOUR DATE OF BIRTH _____
MONTH DAY YEAR

PART 3 – PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

   DATE OF BIRTH _____
   MONTH DAY YEAR

   IF DEPENDENT (CHILD) INDICATE MARRIED ☐ STUDENT ☐ HANDICAPPED ☐

   IF STUDENT, INDICATE SCHOOL _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN W.C.B. OR GOV'T PLAN? NO ☐ YES ☐

   POLICY NO. _____ SPOUSE DATE OF BIRTH _____

   NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO ☐ YES ☐

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. NO ☐ YES ☐

5. IS THIS TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐

6. **AUTHORIZATION**

   I hereby authorize the release to The Norfolk Group or its authorized agents acting on its behalf of any information requested in respect to this claim and certify that the information given is true, correct, and complete to the best of my knowledge. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ DATE _____
EMPLOYEE SIGNATURE OF MONTH DAY YEAR