



La Capitale Insurance and Financial Services Inc.
 Delta 3 Building
 2875 Laurier Blvd, Suite 400
 P.O. Box 1500
 Quebec QC G1K 8X9

**DENTAL INSURANCE
 CLAIM FORM**

INFORMATION ON THE PARTICIPANT

If the information contained in Section A is incorrect or incomplete, please fill in Section B.

A.

Group: _____
 Identification No.: _____

Employer: _____

B.

Name: _____

Address: _____

Postal Code: _____

Phone: _____

Group: _____ Employer: _____

Identification No.: _____

- IMPORTANT**
- For dependent child aged 18 to 26 years old, fill in section 2 on this form.
 - If dental services are necessary as the result of an accident, fill in section 3 on this form and include the **x-ray(s)**.
 - Your claim form must be filled in within 12 months from the date dental expenses were incurred and services received.

1- INFORMATION ON THE PARTICIPANT:

Employer's name: _____

Participant's telephone number: at home _____
 at work _____

Participant's date of birth _____
 Y M D

Are any dental benefits or services provided under any other group insurance or dental plan, or government plan? No Yes

Policy No.: _____

Name of insuring agency: _____

INFORMATION ON THE PATIENT:

Relationship with the participant:

spouse other child

Patient's date of birth _____
 Y M D First name _____

Spouse's date of birth _____
 Y M D

2- STUDENT CERTIFICATE FOR CHILD AGED OVER 17 OR 20 YEARS OLD ACCORDING TO YOUR POLICY

I hereby certify that my child _____ is unmarried and attends the secondary school, college or university _____
 Name of institution for the fall session _____, or winter session _____, as a day student on a full time basis.
 Year Year

3- DENTAL SERVICES REQUIRED AS THE RESULT OF AN ACCIDENT

No Yes If yes, indicate the date, _____
 give some details, and enclose the **X-RAY(S)**. _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER AND CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

 Y M D Participant's signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

(DENTAIRE-A) CPRDA1 (11-03-31)

