DENTAL SUPPLEMENTARY FORM

**To be completed by your Dentist

DENTIST	PATIENT
NAME:	NAME:
ADDRESS:	Green Shield Canada I.D. NO:
CITY / PROV / POSTAL CODE:	

Is any treatment the result of an accident? YES ☐ NO ☐

Is the treatment related to a complete or partial denture? YES ☐ NO ☒

Indicate all missing teeth and the date(s) of extraction(s):

Tooth #	Date Extracted	Tooth #	Date Extracted	Tooth #	Date Extracted	Tooth #	Date Extracted
11		21		31		41	
12		22		32		42	
13		23		33		43	
14		24		34		44	
15		25		35		45	
16		26		36		46	
17		27		37		47	
18		28		38		48	

Also, please indicate any teeth to be extracted: S

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

GREEN SHIELD CANADA
P.O. BOX 1608, WINDSOR, ONTARIO N9A 7G6
ATTENTION: DENTAL DEPARTMENT
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 FAX (519) 739-0046