Insurance

DENTAL ACCIDENT REPORT FORM

PATIENT

NAME:		THIS FORM MUST BE FILLED OUT IN FULL. **INCOMPLETE REPORTS WILL BE RETURNED.** CASE NOTES OR OFFICE MADE REPORTS ARE ONLY ADDITIONAL INFORMATION AND DO NOT REPLACE THE COMPLETION OF THIS REPORT.
ADDRESS:		
CITY/PROV/POSTAL CODE:		PLAN MEMBER ID:
PHONE NUMBER: ( )	DATE OF BIRTH: (YY/MM/DD)	RELATIONSHIP TO PLAN MEMBER:

MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? Yes ☐ No ☐

If yes, insurance company name: _____

If other coverage is RBC Life Insurance Company, indicate Plan Member ID: _____

Is treatment required due to a motor vehicle accident? Yes ☐ No ☐ Is treatment required due to a work-related injury? Yes ☐ No ☐

DATE OF ACCIDENT _____ / _____ / _____ YEAR MONTH DAY	LOCATION OF ACCIDENT PROVINCE/STATE/COUNTRY

DESCRIBE BRIEFLY HOW THE ACCIDENT OCCURRED

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER/PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____ / _____ / _____

PLAN MEMBER'S SIGNATURE YEAR MONTH DAY

DENTIST (MUST BE COMPLETED AND SIGNED BY THE TREATING DENTIST)

NAME:	UNIQUE NO:
ADDRESS:	
CITY/ PROV/POSTAL CODE:	DENTIST'S SIGNATURE
PHONE NUMBER: ( )	_____ / _____ / _____ **YEAR MONTH DAY**

DESCRIPTION OF DAMAGE **(please include tooth numbers)**:

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 RBC Life Insurance Company about myself and my dependents, will be used by RBC Life Insurance Company 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 RBC Life Insurance Company 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.

ALL PREDETERMINATIONS OR ANY INCURRED CLAIMS MUST BE MANUALLY SUBMITTED INDICATING DENTAL ACCIDENT, XRAYS ARE REQUIRED.
ATTN: DENTAL ACCIDENT, PO BOX 1614, WINDSOR, ON N9A 0B9
1-855-264-2174

The cost, if any, of obtaining this information is at the expense of the patient/plan member.