Dental claim form

people CORPORATION®
Experience the Benefits of People

Submit to: 1403 Kenaston Blvd., Winnipeg MB R3P 2T5
Scan and email to: claims.inquiries@peoplecorporation.com
Inquiries: 1-800-875-7982 **Fax:** 204-488-6008

The personal information we collect from you is kept in strict confidence and will be used only to assess your claim.

Patient details	**Dentist unique number**		**Assignment of benefits**
Name:	Name:		I hereby assign my benefits payable from this claim and authorize payment directly to the named dentist. **Employee signature:** X_____
Address:	Address:		
City/Province:	City/Province:		
Postal code:	Postal code:	Phone:	

Date of service Day	Month	Year	Procedure code	Tooth code	Tooth surface	Dentist fee	Lab charge	Total fee

Insurance info:

Employee name: _____
Birthdate:_____Gender:_____
Employer:_____
Group #:_____Cert#: _____
Relationship to patient: _____
Patient birthdate: _____

Co-insurance/Second payor info:

Name of family member insured: _____
Birthdate:_____Gender:_____
Relationship to patient: _____
Name of company: _____
Group #:_____Cert#: _____

Dentist use only:

1. Treatment resulting from: ☐ Accident ☐ Workplace illness or injury
   Details: _____
2. Treatment involving: ☐ Denture ☐ Crown ☐ Bridge
   Initial placement date & reason for replacement: _____
3. Additional information or special consideration:

This is an accurate statement of services performed and the total fee due and payable, errors and omissions accepted.

Dentist signature: X_____

Authorization:

I authorize People Corporation, its advisors and service providers, any healthcare provider, other insurance companies, other organizations, or benefit service providers to exchange information when necessary to assess my claim and administer the group benefit plan.

I certify the answers given are true, correct and complete to the best of my knowledge. If this claim is being made on behalf of my spouse or dependants, I am authorized to disclose information about them, for the purpose of assessing and paying a benefit, if any.

I understand that the fees listed in this claim may not be covered or may exceed my insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

Employee signature: X _____