Claim Request - Dental Care Benefits or Treatment Plan

Important: Fill out in block letters and answer each section as accurately as possible.

Section A – Collection, Use and Disclosure of Personal Information

This form allows UV Insurance to collect personal information from the dentist regarding a claim for dental care benefits or a dental treatment plan.

The personal information collected is used to:

- Identify the individual
- Establish and update information and the needs of the individual, as appropriate
- Comply with legal and regulatory requirements, including tax rules and the prevention, detection and enforcement of offences, cyber threats and fraud

The information disclosed on this form will be forwarded to the UV Insurance staff responsible for processing the application, as well as to any other person authorized by law.

Section B – Information

Note: Section B and Section D are to be completed by the dentist.

Patient information

1. First name _____ Last name _____
2. Address _____

City _____ Province _____ Country _____ Postal code _____

Dentist information

1. First name _____ Last name _____
2. Address _____

City _____ Province _____ Country _____ Postal code _____

3. Phone ( ) - 4. Licence number _____

Treatment

☐ **Estimate or treatment plan (no treatment dates should appear on the form.)**

Fees do not take into account complications that may arise during or after treatment. Laboratory fees are approximate. Benefits will be subject to the restrictions of the plan in effect at the date of care, such as the maximum amount payable per period as set out in the contract. This estimate is valid for 12 months only.

Treatment date	Procedure code	Tooth number	Surface or sextant	Laboratory fees	Dentist's fees	Total amount
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
Y M D				$	$	$
					Total fees claimed	**$**

1. In the case of a dental prosthesis, crown or bridge, is this the first time it has been placed? ☐ Yes ☐ No
   If **No**, please indicate the date of the previous placement and the reason for replacement.
   Date Y M D Reason _____
2. If any of the above treatments are required as a result of an accident, please indicate the date and nature of the accident.
   Date Y M D Nature of the accident _____
3. Is orthodontic care required? ☐ Yes ☐ No

For dentist use only

Additional information on diagnosis, procedures, complications and special cases.

Section C – Insured's Information

Note: To be completed by the insured

1. First name _____ Last name _____
2. Group no. _____ Certificate no. _____
3. If this is a claim for a dependant, please indicate the relationship and their date of birth.
   ☐ Spouse ☐ Child ☐ Student Date of birth Y M D
4. Are dental benefits payable under another insurance policy? ☐ Yes ☐ No
   If **Yes**, provide the contract number and insurer name _____

Section D – Consent and Signatures

By signing this form, you understand that in the event any of the personal information provided herein is inaccurate, incomplete or ambiguous, you may request a correction by submitting a request to UV Insurance.

You also have the right to request information about how your personal information is used. In addition, you may withdraw your consent to the disclosure or use of your personal information at any time by making a request to the UV Insurance Privacy Officer at the following address: 1990 Jean-Berchmans-Michaud Street, Drummondville, QC J2C 7G7.

For more details, please visit our website and see our **Privacy Policy.**

The fees and expenses listed on this form may not be covered by the insured's policy or may only be partially covered. Therefore, the undersigned understands that it is their responsibility to ensure that their dentist is fully compensated for the treatment provided. The undersigned consents to the disclosure of all information contained in this application to their insurer or its agents.

In addition, by signing this form, the undersigned consents to the collection of their personal information so that UV Insurance can evaluate this application and contact the relevant healthcare professionals, including general dentists, dentist specialists, denturists or dental hygienists strictly required for the analysis of this claim.

Finally, the undersigned confirms having read and accepted the information provided in this form.

This consent also applies to the collection, use and disclosure of the beneficiaries' personal information, and the undersigned confirms that prior consent has been obtained from such beneficiaries.

Signatures

By signing below, the undersigned certifies that the information provided is complete and true and that a photocopy of this document is of the same value as the original.

X _____ _____ Date Y M D

Signature of patient (or parent/guardian) Name of signatory (please print)

As the dentist, I declare that I am acting in accordance with privacy laws and regulations.
By signing this form, I confirm that the information provided is accurate. This is an accurate statement of the care provided or to be provided under a treatment plan and of the fees claimed, except for errors and omissions.

X _____ _____ Date Y M D

Signature of dentist Name of signatory (please print)