Form 408-3

Saskatchewan Teachers' Dental Plan
Dental Claim/Estimate Form

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTISTS AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

Signature of teacher

Part 1 - Dental Office

Group #25273

Claim number

Dentist name:
Address:
City, Prov.:
Postal Code:
Telephone:
Unique I.D.#:

Patient's last name Given name

Address

City Prov. Postal Code

Date of Service Day	Mo.	Yr.	Intl. tooth code	Procedure code	Tooth surface	Laboratory charge	Dentist's fee	Total charge	For use by Sun Life Assurance Company: Lab fee	Schedule fee	Override code	Message code

Total submitted fee

For dentist's use for additional information re: diagnosis, procedures or complications and special considerations.

I hereby certify that the services listed

☐ Have been performed ☐ Are an estimate only

This is an accurate statement of services performed and fees charged E & O.E.

Dentist Signature Date

Part 2 - Teacher

TEACHER'S CERTIFICATE NO.

Teacher's Last Name: Given Name:

Address: Employee Date of Birth: year month day

City: Phone No. Home:

Prov. Postal Code: Work:

Employing School Division:

Patient's relationship to teacher: Self ___ Spouse ___ Dependent Child ___

(Refer to page 6 in the Teachers' Dental Plan booklet)

Patient's Date of Birth: year month day

(REVERSE SIDE MUST BE COMPLETED)

Saskatchewan Learning

DENTAL CLAIM FORM Approved by the COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

Forward Claim To:
Sun Life Assurance Co. of Canada
Health Claims Office
Box 2880, Stn. Main
Edmonton, AB T5J 4S6

(To be completed by the Teacher)

Important: If any information is missing or incomplete the claim will be returned

1. If crown or bridge, is this initial placement? ☐ Yes ☐ No
   If yes, send pretreatment x-rays.
   If no, date of prior placement _____ (year month day) reason for replacement _____
   If bridgework is initial placement, is patient wearing a partial denture, or ever had a partial denture? ☐ Yes ☐ No
   If yes, date of prior placement _____ (year month day) reason for replacement _____

2. If denture, is this initial placement?
   ☐ Yes ☐ No
   If no, date of prior placement _____ (year month day) reason for replacement _____

3. Is patient entitled to coverage under any other insurance or dental plan for these services listed on this claim?
   ☐ Yes ☐ No
   ☐ Worker's Compensation ☐ Saskatchewan Government Insurance ☐ Medical Care Insurance Commission
   ☐ Other dental plan (identify) _____
   ☐ Other gov't program (identify) _____
   ☐ Spouse's plan: Employer _____ Insurance Carrier: _____

4. If claim is for dependent child, please provide spouse's birthdate: _____ (year month day) and employee's birthdate: _____ (year month day)

5. Has payment been made by any insurance or dental plan for services listed on this claim? ☐ Yes ☐ No
   If yes, attach a copy of reimbursement showing the procedures and amounts reimbursed.

6. This is a: ☐ claim for benefits ☐ estimate

A teacher is eligible if he/she has been employed on a contract of employment (Section 200 of *The Education Act*) for at least 20 occasions of teaching. Teachers receiving disability benefits under the STF Income Continuance Plan and / or the Teachers' Superannuation Plan are covered under the Plan. Teachers who have temporary or replacement contracts must have their school board authorize their dental claim.

I certify that I am currently teaching under contract with a Saskatchewan School Board and to the best of my knowledge am eligible for coverage under the Saskatchewan Teachers' Dental Plan.

I authorize the release of any information requested in respect of this claim to the Claims Administrator, or its agents, and certify that the information given is true, correct, and complete to the best of my knowledge. I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the dentist/denturist for the entire cost of the treatment.

Signature of teacher _____ Date _____

Part 3 - Employing School Division

(To be completed if claim is for a temporary/replacement teacher)

I verify that the above temporary/replacement teacher qualifies for dental coverage. The contract termination date if known: _____ Date

Employing School Division - Authorizing Signature _____ Date _____

Forward to the Teachers' Superannuation Commission after authorization.