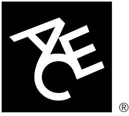

ACE INA Insurance
ACE INA Life Insurance
1400 – 25 York Street
Toronto, Ontario M5J 2V5
Telephone: 416-594-2627 1-877-772-7797

CANADIAN ACTORS' EQUITY ASSOCIATION ACCIDENTAL DENTAL CLAIM FORM

PLEASE COMPLETE ALL DATES IN MONTH/DAY/YEAR FORMAT

TO BE COMPLETED BY INSURED/GUARDIAN

☐ **SCG 100005 Base Plan** ☐ **SCG 102067 Top Up Plan**

Full name of Claimant		
Address		
City	Province	Postal Code
Date of Birth	Phone # ( )	
Please provide full details of accident		

The above statements are true and correct to the best of my knowledge and belief. I authorize, for a period of not less than twelve (12) and twenty-four (24) months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, insurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with ACE INA Insurance or ACE INA Life Insurance, or its representatives, all medical or benefit payment information or any other information or records in its possession that the Insurer may request while administrating my claim. I agree that a photocopy of this authorization shall be as valid as the original.

Claimant's Signature ________________________________

TO BE COMPLETED BY DENTIST:
FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment.

I acknowledge that the total fee $____________is accurate and has been charged to me for services rendered.
I authorize release of the information contained in this claim form to my insuring company/plan administrator.

Date of Service	Procedure Code	Intl Tooth Code	Tooth Surface	Dentist's Fee	Laboratory Charge	Total Charges

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND TOTAL FEE DUE AND PAYABLE. E & OE

Total Fee Submitted ________________________________

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CANADIAN ACTORS' EQUITY ASSOCIATION
ACCIDENTAL DENTAL CLAIM FORM

Please provide full details of accident / incident:

Description of Damage

Is further treatment required ☐ No ☐ Yes If "Yes", please provide details:

	Treatment Indicated (use Procedure Code if possible)	**Estimated Treatment Date**

Describe further potential problems and indicate time frame:

Name of Dentist	Dentist's Phone # ( )
Dentist's Fax # ( )	Dentist's Address

Dentist's Signature ______________________________

EQUTY MEMBER TO SUBMIT CLAIM DIRECTLY TO ACE INA INSURANCE