Sirius Benefits
Sirius Benefits is a People Corporation Company

DENTAL CLAIM FORM

SUBMIT TO: 3227 Roblin Boulevard, Winnipeg MB R3R 0C2

FAX TO: 204-488-6008 **SCAN & E-MAIL TO:** info@siriusbenefits.ca

INQUIRIES: 1.800.663.8833

The personal information we collect from you is kept in strict confidence and will be used 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.
Address:	Address:	
City/Province:	City/Province:	**EMPLOYEE SIGNATURE:**
Postal Code:	Postal Code: Phone #:	X_____

DATE OF SERVICE DAY	MONTH	YEAR	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACE	DENTIST FEE	LAB CHARGE	TOTAL FEE
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00

INSURANCE INFO:

Employee Name: _____

Birthdate: dd/mm/yyyy Gender: _____

Employer: _____

GROUP #: _____ CERT#: _____

Relationship to Patient: _____

Patient Birthdate: dd/mm/yyyy

CO-INSURANCE/SECOND PAYOR INFO:

Name of Family Member Insured: _____

Birthdate: dd/mm/yyyy 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: dd/mm/yyyy
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 Sirius Benefit Plans, 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 dependents, 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 responsiblefor the entire cost of services received and that this claim is for reimbursement of eligible charges.

EMPLOYEE SIGNATURE: X _____