

Part 3 – Dental Accident Supplementary Questionnaire for Insured Subscriber

Policy No.: _____

Date of accident D _____ M _____ Y _____ Time of accident? _____ a.m. p.m.

Where did accident occur? _____

Describe how accident occurred? _____

Nature of injury? _____

If taken to hospital, name of hospital? _____

Date admitted D _____ M _____ Y _____ Time _____ a.m. p.m.

Date discharged D _____ M _____ Y _____ Time _____ a.m. p.m.

Dentist's Name _____ Date first treated D _____ M _____ Y _____

Part 4 – Employee / Plan Member / Subscriber (if covered under other plans(s))

Your Name _____ Date of Birth D _____ M _____ Y _____

Group Policy / Plan Number _____ Division / Section Number _____

Employer _____

Name of insuring agency or plan _____

Part 5 – Patient Information

Patient _____ Relationship to Employee/Plan Member/Subscriber _____

Date of Birth D _____ M _____ Y _____ If child, indicate Student Handicapped

If student, indicate school _____

Do you have coverage for dental expenses under any of the following:

Group Health Plan? Yes No Plan Name/Policy No. _____

Group Dental Plan? Yes No Plan Name/Policy No. _____

W.C.B. Plan? Yes No Plan Name/Policy No. _____

Government Plan? Yes No Plan Name/Policy No. _____

I certify that to the best of my knowledge that the statements made above are true, correct and complete.

Signature of Plan Member/Subscriber _____ Date D _____ M _____ Y _____

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Part 6 – Policyholder / Employer (for completion only if applicable)

Date coverage commenced? D _____ M _____ Y _____ Date terminated D _____ M _____ Y _____

Date dependent covered? D _____ M _____ Y _____

Policyholder _____

Address _____

Signature of Policyholder/Employer _____ Print Name _____

Position/Title _____ Date D _____ M _____ Y _____ Telephone () _____