

# UNITE HERE HEALTH & WELFARE PLAN

**Administered by  
SOBEN LTD.  
150 Consumers Rd., Ste 302  
Toronto, Ont. M2J 1P9  
Tel: (416) 498-8338 • Toll Free: 1-888-887-6879 • Fax: (416) 498-4591**

## DENTAL PLAN CLAIM FORM

### INSTRUCTIONS TO MEMBER

1. Complete the Employee's statement (below) on each form sent in.
2. Have the attending Dentist complete and sign statement on back.
3. All correspondence, claim forms etc.... should be mailed to:

Soben Ltd.  
150 Consumers Rd., Ste 302  
Toronto, Ont. M2J 1P9

4. Your Social Insurance Number

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5. Your place of employment \_\_\_\_\_

6. Telephone Numbers: Home: \_\_\_\_\_ Business \_\_\_\_\_

### MEMBER'S STATEMENT

**N.B. Any recommended course of treatment involving fees of \$500 or more must be submitted along with x-ray's to the administrator for insurer approval before a claim can be made.**

1. Name of insured	Address (give number, street, city & prov.) Postal Code	2. Date of birth Day / Month / Year	Date of employment Day / Month / Year
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3. Name of patient	Relationship to insured	Date of birth	Occupation
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4. If child age 21 or over, indicate: <input type="checkbox"/> Student <input type="checkbox"/> Handicapped If student, furnish proof of school registration.	5. Is any treatment for orthodontic purposes? <input type="checkbox"/> no <input type="checkbox"/> yes
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6. If denture crown or bridge, is this initial placement?  no  yes  
Give date of prior placement and reason for replacement:

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7. Is this dental care covered by another group insurance or dental care plan?  no  yes

Policy number:..... Certificate number:.....

Name of insurance company:.....

Covered as  insured  dependent

If dependent, name of the insured:.....

8. Is treatment required due to an accident?  no  yes

Indicate date and specify:.....

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9. Is claim being made for workmen's compensation?  no  yes

10. I hereby certify that the above information is true and that these expenses were incurred for the exclusive use of the person(s) named above. I authorize any medical practitioner, hospital, employer, UNITE HERE Ontario Council, drug card provider and insurance company to release to the UNITE HERE Health & Welfare Plan and its agents any information relevant to this claim. I authorize the UNITE HERE Health & Welfare Plan and Pension Plan and their agents to use my social insurance number for identification purposes and to use any of the information provided, for the purpose of administering the benefit plans.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

