the co-operators®
A Better Place For You®

GROUP BENEFITS SUPPLEMENTARY DENTAL ACCIDENT REPORT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Dental Claims Department
1920 College Avenue
Regina, SK S4P 1C4

Fax: (306) 761-7101

INSTRUCTIONS

To be eligible for coverage:
(a) all planned treatment must be completed within 365 days from the date of the accident and
(b) the patient must be an insured member under the group referred to below on the date(s) Dental services are rendered.

Any expenses related to this accident must be submitted manually (paper claim, not EDI) and clearly indicated as an accident on the paper submission.

PART 1 - PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Plan Sponsor/Employer _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Patient _____ (First Name) _____ (Initial) _____ (Last Name)

PART 2 - ACCIDENT INFORMATION

Date of accident _____ (MMM/DD/YYYY)

Describe the cause of accident (eg. sport, motor vehicle accident, etc.) _____

Describe the damage to whole sound teeth (indicate any involved teeth that have been crowned, bridged or endodontically treated) _____

Is further treatment indicated? ☐ Yes ☐ No If Yes, please indicate in the table below:

Tooth Code	Treatment Indicated (use procedure code if possible and approximate fee)	Estimated Treatment Date (MMM/DD/YYYY)

Describe further potential problems and indicate time frame _____

PART 3 - DENTIST AUTHORIZATION

I hereby certify that the information provided in this document is true, complete and accurate.

Dentist Signature _____ Date _____ (MMM/DD/YYYY)

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.