THE Great-West Life ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT

SEND THIS CLAIM TO:

Questions? Call Toll Free: 1.800.957.9777

Regina Benefit Payments
P.O. Box 4408
Regina SK S4P 3W7

For the deaf or hard of hearing:
Toll Free: 1.800.990.6654

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

PART 1 EMPLOYEE INFORMATION

PLAN NUMBER	DIVISION NUMBER	PLAN NAME	
EMPLOYEE IDENTIFICATION NUMBER		EMPLOYEE NAME	DATE OF BIRTH (Year / Month / Day)
ADDRESS: NUMBER AND STREET	TOWN	PROVINCE POSTAL CODE	PHONE # HOME: WORK:

PART 2 COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If yes, name of family member insured _____ Relationship to employee _____

Name of other insurance company _____ Policy Number _____

Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

If yes, name of family member _____

If yes, to either question above, and the patient is a dependent child, please provide spouse's date of birth: _____ / _____ / _____ (Year / Month / Day)

Is treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location and explain how accident happened

_____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

PART 3 DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth Year	Month	Day	Does patient reside with you? YES NO	Full-Time Student? YES NO	If child over 18 years: If student, how many hours per week?	Employed? YES NO	How many hours worked per week?
					☐ ☐	☐ ☐		☐ ☐	
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					☐ ☐	☐ ☐		☐ ☐	

PART 4 CLAIM DETAILS *(If additional space is needed, attach a separate page)*

DRUG EXPENSES

Patient Name	Number of Receipts	Total Charge

OTHER EXPENSES

Type of Expense	Nature of Illness	Total Charge

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

Great-West
COMPAGNIE D'ASSURANCE-VIE

RELEVÉ DES FRAIS MÉDICAUX

DIRECTIVES : Il est important de donner le détail des frais et d'annexer les factures et les reçus.
À noter : Les factures et les reçus de médicaments, autres que ceux exigés aux termes des régimes d'assurance-médicaments d'État, font partie intégrante de nos dossiers et ne seront pas retournés. Par conséquent, veuillez conserver, aux fins de la déclaration de revenus, le détail du règlement que nous vous ferons parvenir, accompagné ou non d'un chèque.

IMPORTANT : Veuillez répondre à toutes les questions. La présente demande sera retournée si les renseignements nécessaires sont erronés ou incomplets. Toutes les demandes de règlement aux termes du régime collectif sont soumises par le truchement du participant du régime. Il se peut que nous échangions des renseignements personnels au sujet des demandes de règlement avec le participant et avec une personne agissant en son nom, au besoin, aux fins de la vérification de l'admissibilité et de la gestion des demandes de règlement.

ENVOYEZ LA PRÉSENTE DEMANDE À :

Questions : 1 800 957-9777 (sans frais)

Service des indemnités de Regina
Case postale 4408
Regina (Saskatchewan) S4P 3W7

Pour les sourds et les malentendants :
Numéro sans frais : 1 800 990-6654

En caractères d'imprimerie s.v.p.

PARTIE 1 RENSEIGNEMENTS SUR LE SALARIÉ

RÉGIME N°	DIVISION N°	NOM DU RÉGIME

NUMÉRO D'IDENTIFICATION DU SALARIÉ	NOM DU SALARIÉ	DATE DE NAISSANCE (Année / Mois / Jour)

ADRESSE : NUMÉRO ET RUE	VILLE	PROVINCE	CODE POSTAL	N° DE TÉLÉPHONE
				DOMICILE : TRAVAIL :

PARTIE 2 COORDINATION DES PRESTATIONS

Avez-vous droit ou un membre de votre famille a-t-il droit à des prestations d'un autre régime? ☐ Oui ☐ Non

Dans l'affirmative, indiquez le nom du membre de la famille assuré. _____ Lien de parenté avec le salarié _____

Nom de l'autre assureur _____ Numéro de la police _____

Un des membres de votre famille (à l'exclusion de vous-même) est-il couvert à titre de salarié par le présent régime? ☐ Oui ☐ Non

Dans l'affirmative, indiquez le nom du membre de la famille assuré. _____

Dans l'affirmative à l'une ou l'autre question ci-dessus, et si le patient est un enfant à charge, indiquez la date de naissance du conjoint ____ /____ /____
Année Mois Jour

Le traitement est-il nécessaire par suite d'un accident? ☐ Oui ☐ Non

Dans l'affirmative donnez la date et l'endroit de l'accident et décrivez ce qui s'est produit.

_____

Une demande de règlement a-t-elle été présentée à la CSST? ☐ Oui ☐ Non

PARTIE 3 RENSEIGNEMENTS SUR LES PERSONNES À CHARGE

Nom du patient	Lien de parenté avec le salarié	Date de naissance Année	Mois	Jour	Le patient habite-t-il avec vous? OUI NON	Étudie-t-il à temps plein? OUI NON	Enfant de plus de 18 ans : S'il est étudiant, combien d'heures de cours a-t-il par semaine?	Travaille-t-il? OUI NON	Combien d'heures par semaine?
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					☐ ☐	☐ ☐		☐ ☐	
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PARTIE 4 RENSEIGNEMENTS SUR LA DEMANDE DE RÈGLEMENT *(Si vous avez besoin de plus d'espace, annexez une feuille.)*

FRAIS DE MÉDICAMENTS

Nom du patient	Nombre de reçus	Total des frais

AUTRES FRAIS

Type de frais	Nature de la maladie	Total des frais

À la Great-West, nous reconnaissons et nous respectons l'importance de la vie privée. Les renseignements personnels recueillis serviront à l'évaluation de la demande de règlement et à l'administration du régime collectif. Pour obtenir un exemplaire de nos Normes de confidentialité ou si vous avez des questions sur nos politiques et pratiques en matière de renseignements personnels (y compris en ce qui a trait aux fournisseurs de service), écrivez au chef de la vérification de la conformité de la Great-West ou consultez l'adresse www.lagreatwest.com.

J'autorise la Great-West, tout fournisseur de soins de santé, le gestionnaire du régime, toute autre compagnie d'assurance ou de réassurance, les administrateurs des programmes d'État ou de tout autre programme d'avantages sociaux, toute organisation ou tout fournisseur de services travaillant avec la Great-West, situés au Canada ou à l'étranger, à échanger les renseignements personnels nécessaires aux fins précitées. Il est entendu que les renseignements personnels peuvent être divulgués aux personnes autorisées en vertu des lois applicables au Canada ou à l'étranger. J'atteste que les renseignements donnés sont à ma connaissance véridiques, corrects et complets.

Signature du salarié _____ Date _____

THE Great-West Life ASSURANCE COMPANY

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Signature du salarié _____ Date _____

Short-Term Disability Income Benefit

Employee's Statement

Great-West Life

your Benefits Solutions People

For members of _____

HOWE SOUND PULP & PAPER CORPORATION

THE Great-West Life ASSURANCE COMPANY

Employee's Statement
Short Term Disability Income Benefits

This guide contains the forms you need to apply for disability benefits and some important information about the claim process.

These forms should be submitted within five days of the onset of your disability. Your notice form, and any other correspondence you may wish to provide about your claim, should be submitted to the Great-West Life disability management services office assigned to assess your claim. Should you wish to submit your notice form directly to Great-West Life, please contact your employer for the appropriate mailing address.

1. **Notice of Claim**

   The Notice of Claim asks general information about you, your job and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form.

   Note: If you have Guaranteed Standard Issue Program coverage with Great-West Life, this form will be used as Notice of Claim for that coverage as well.

2. **Authorization Request**

   We need your permission to obtain information that will help us assess your claim. By signing this authorization request, you give Great-West Life permission to obtain this information from your doctor, your employer, other insurers and hospitals where you received treatment.

3. **Attending Physician's Report**

   Ask your doctor to complete this form. It requests general information about your condition.

WHAT YOU SHOULD KNOW ABOUT THE CLAIM PROCESS

Employer's Statement

Before we can assess your claim, we need a statement from your employer confirming the date your insurance coverage began, your job duties and earnings. We have asked your employer to supply this information directly to us.

Claim Assessment

We will assess your claim as soon as we receive these completed forms from you, your doctor and your employer.

We will notify you promptly if you are eligible for disability benefits and explain any limitations that may apply.

Medical Information

You are responsible for providing medical proof that you are entitled to receive disability benefits. This information must be supplied by your doctor(s) who may charge a fee for preparing it. If they do, you are responsible for paying for it. When Great-West Life requests information directly from your doctor, we will offer to pay a correspondence fee for it.

Medical Coordination/Vocational Rehabilitation

A Medical Coordinator or Vocational Rehabilitation Consultant may contact you during the course of your disability to help you develop a return-to-work plan.

THE
Great-West Life
ASSURANCE COMPANY

NOTICE OF CLAIM

Identification

1. ☐ Mr. ☐ Mrs. ☐ Ms.

   Your Name: First _____ Initial _____ Last _____

   Address: Street & Number _____

   P.O. Box _____

   City _____ Province _____ Postal Code _____

   Telephone: Home (_____) _____ Work (_____) _____

   Cell (_____) _____

2. Your GWL Employee Identification Number _____

   Your Identification number must be completed. If unknown, please check with your employer.

3. Social Insurance Number _____

   If your employer pays for all or any part of your disability benefits coverage, any benefits payable may be subject to income tax. If this applies to you, please provide your Social Insurance Number for income tax reporting purposes. Your Social Insurance Number may also be used as an identification number where required in the administration of benefits.

4. Date of birth: Year _____ Month _____ Day _____

Employer Information

1. Your Employer's Name: **HOWE SOUND PULP & PAPER CORPORATION**

   Address: Street & Number 3838 PORT MELLON HWY.

   City PORT MELLON Province BC Postal Code V0N 2S0

   Telephone Number: (604) 884-2334

2. Group Plan Number **164157**

Claim Information

1. What is the nature of your condition? _____
2. If disability is due to an accident, give date accident occurred: Year _____ Month _____ Day _____

   Where and how did it occur? _____

   Was the accident work-related? ☐ Yes ☐ No
3. From what date has your disability continuously prevented you from performing your regular work?

   Year _____ Month _____ Day _____
4. Have you performed any **other** work since that date? ☐ Yes ☐ No

   If yes, describe _____
5. Are you able to do any other work? ☐ Yes ☐ No

   If yes, describe _____
6. Please provide the name(s) and telephone number(s) of your attending physician(s).

   _____

Financial

1. Have you applied for, or are you receiving the following:

	I have Applied		I am Receiving		
	Yes	No	Yes	No	Amount
Canada Pension Plan/Quebec Pension Plan Benefits	☐	☐	☐	☐	$ _____
Workers' Compensation Board Benefits (or similar plan)	☐	☐	☐	☐	$ _____
Employment Insurance Benefits	☐	☐	☐	☐	$ _____
Automobile Insurance Benefits	☐	☐	☐	☐	$ _____
Any other Disability Benefits	☐	☐	☐	☐	$ _____
Employer Sponsored Retirement / Pension Plan Income	☐	☐	☐	☐	$ _____
Self Employment Income or any other Employment Income			☐	☐	$ _____
Any other income	☐	☐	☐	☐	$ _____

For the duration of your claim for benefits, it is your responsibility to notify Great-West Life of:

- any work performed, whether or not you have received a wage or remuneration, or
- any employment income paid to you or any other person or party as a result of work performed by you.

2. Do you have Individual Disability, Creditor, Critical Illness, or Life Insurance Coverage with Great-West Life, Canada Life or London Life? ☐ Yes _____ Plan Number ☐ No

IF YOU ARE RECEIVING ANY OF THE ABOVE, PLEASE SUPPLY COPIES OF THE INITIAL BENEFIT STATEMENTS.

DIRECT DEPOSIT AUTHORIZATION

You can have your benefit payments automatically deposited to your bank account with Electronic Funds Transfer (EFT) from Great-West Life. **All benefit payments covered under one plan number will be deposited into the same bank account.**

If you'd like to take advantage of Electronic Funds Transfer, please fill in the information below.

Effective _____ please deposit my payments to the following account
(date)

☐ Savings Account, (please consult your bank for proper bank identification number.)

☐ Chequing Account, (please attach sample cheque marked "VOID")

PLEASE PRINT

NAME OF BANK, TRUST CO., CREDIT UNION, ETC.	TRANSIT NO. INSTITUTION NO. ACCOUNT NO.
BRANCH ADDRESS	NAME IN WHICH ACCOUNT IS HELD
CITY OR TOWN & PROVINCE POSTAL CODE	

NOTE: FOR INSTITUTIONS WITHIN CANADA ONLY

SIGNATURE OF EMPLOYEE _____ DATE _____

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. This information about you may include medical and psychiatric information. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. We use the personal information to investigate and assess your claim(s), to administer coverage that you may have with Great-West Life and to administer the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- Great-West Life, any healthcare or rehabilitation provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or other benefits programs, any person having knowledge of me or my health, other organizations, or service providers working with Great-West Life or the above to exchange my personal information, when relevant and necessary for the purposes of investigating and assessing my claim(s), administering coverage that I may have with Great-West Life and administering the group benefits plan. This may include performing independent assessments;
- Great-West Life to exchange my personal information with my employer, plan sponsor, or plan administrator when relevant for the purposes of discussing rehabilitation and return-to-work planning;
- Great-West Life to disclose personal information about my claim(s) to an auditor authorized by my employer, plan sponsor, or their agent, or by Great-West Life for the purpose of auditing the assessment of claims;
- Great-West Life to use my Social Insurance Number for income tax reporting purposes and as an identification number where required in the administration of benefits.

I acknowledge that the personal information is needed to investigate and assess my claim(s), to administer coverage(s) that I may have with Great-West Life and to administer the group benefits plan. I acknowledge that my consent enables Great-West Life to process my claim(s) and that refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

Except for audit purposes, the authorizations shall remain valid for the duration of my claim for benefits or until otherwise revoked by me.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I declare that the statements provided in this Statement and any statements provided in any personal or telephone interview concerning my claim(s) for disability benefits are true and complete. I agree that all such statements form the basis for any benefit approved.

Print Name	Signature
Date	Telephone Number

THE Great-West Life ASSURANCE COMPANY

INITIAL ATTENDING PHYSICIAN'S STATEMENT
SHORT TERM DISABILITY INCOME BENEFITS

This is not a request for examination but for information taken from your chart. The patient is responsible for securing this form and any charges for its completion.

Name of Patient: _____ Employee Identification # _____

Name of Employer: **HOWE SOUND PULP & PAPER CORPORATION** Plan Number **164157**

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Date: _____ Signature of Patient: _____

1. **History**

   Date symptoms first appeared or accident happened. Year _____ Month _____ Day _____

   Has patient ever had the same or similar condition? ☐ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment _____

   _____

2. **Diagnosis** (including any complications)

   Primary _____

   Secondary _____

   Subjective Symptoms: _____

   Objective signs (including results of current X-rays, blood pressure, laboratory data and any relevant clinical findings): **Please attach a copy of your clinical notes and all relevant test results and consultation reports related to this period of disability.**

   _____

   _____

3. Current Height _____ Current Weight _____

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year _____ Month _____ Day _____

5. **Treatment**

   What is the current treatment regimen? (drug dosage, physio, other and progress)

   _____

   _____

   _____

   Please indicate all dates of visits for the current condition:

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

6. If condition is due to pregnancy, what is (or was) the expected date of confinement?

   Year _____ Month _____ Day _____

7. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No
   If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

8. Please indicate your patient's current physical abilities:

   ☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

   ☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

   ☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

   ☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

   List physical restrictions and tolerances: _____

   In your opinion, what is the earliest date your patient will be able to return to work?

   Year _____ Month _____ Day _____

   If the previous job could be modified, when could rehabilitation employment commence?

   Year _____ Month _____ Day _____

9. Please provide the names of other physicians who have been/will be involved in assessing the medical problems.

   _____

   _____

10. **Hospitalization** if applicable for this illness or injury

    Date of in-patient admission: Year _____ Month _____ Day _____

    Date of discharge: Year _____ Month _____ Day _____

    Date of out-patient treatment: Year _____ Month _____ Day _____

    Name of hospital: _____

11. **Surgery**

    Surgical procedure performed: _____

    Date of surgery: Year _____ Month _____ Day _____

    Name of surgeon: _____

12. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

    _____

    _____

Name of Physician (please print) _____

Specialty _____

Telephone: _____ Fax: _____

Address (number, street, city, province & postal code):

_____

Physician's signature _____ Date _____

THE
Great-West Life
ASSURANCE COMPANY

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STANDARD DENTAL CLAIM FORM

Please print

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association

PART 1 DENTIST

UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.

PATIENT
LAST NAME GIVEN NAME
ADDRESS APT.
CITY PROV. POSTAL CODE

DENTIST
PHONE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

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 OF $ _____ 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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____

DUPLICATE FORM ☐

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL.TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

PART 2 EMPLOYEE INFORMATION

Plan Number 58119 Division Number _____ Employee Identification Number _____

Plan Name HOWE SOUND PULP & PAPER CORPORATION

Employee Name _____ Date of birth ____ / ____ / ____ (Day Month Year)

Employee address _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you _____ 2. Patient's date of birth ____ / ____ / ____ (Day Month Year)
3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No
4. If the child is over 18: a) Is he/she a full-time student? ☐ Yes ☐ No
   b) If student, how many hours per week at school? _____
   c) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____
5. a) Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No
   If yes, name of family member insured _____ Relationship to employee _____
   Name of other insurance company _____ Policy Number _____
   b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No
   c) If yes to questions 5 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____ / ____ / ____ (Day Month Year)
6. Is this treatment required as the result of an accident? ☐ Yes ☐ No
   If yes, give date, location, and explain how accident happened _____
7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement.

M445D BIL-11/09