

Details of Claim

1. Major restorative or prosthodontic claims (e.g. crowns, inlays, bridges, dentures, etc.)

Is this the initial placement? No <input type="checkbox"/> Yes <input type="checkbox"/>	
If No, • Date of prior placement: _____ / _____ / _____ Day Month Year • Reason for replacement: _____	Date dentist took impression for this treatment: _____ / _____ / _____ Day Month Year
Please ask your dentist to include the following to facilitate handling of your claim: • Pre-treatment x-rays (for crowns, inlays, onlays, veneers and bridges only).	

2. Are any expenses the result of an accident? No Yes If yes, complete the following:

When and where did the accident occur? Day _____ Month _____ Year _____ / /	Work <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/>
How did the accident occur?	
Are any expenses the result of a condition covered by Workers' Compensation/Workplace Safety and Insurance Board? No <input type="checkbox"/> Yes <input type="checkbox"/>	

3. Orthodontics

Is this treatment for orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>	Date initial appliance was installed: _____ / _____ / _____ Day Month Year
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Coverage Under Other Benefit Plans

Are you covered for any of these expenses under any other benefit plan as an active employee? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes: You must submit a claim to your employee plan first ; then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.	
Are you covered for any of these expenses under any other benefit plan as a pensioner? No <input type="checkbox"/> Yes <input type="checkbox"/> Please indicate: Name of Insurer: _____ Contract Number: _____ Certificate Number: _____	
Is your spouse, common law partner, or child covered for any of these expenses under any other benefit plan? No <input type="checkbox"/> Yes <input type="checkbox"/> Spouse or common law partner's date of birth: _____ / _____ / _____ Day Month Year	
If yes: • You must submit a claim for your spouse or common law partner to their plan first . • You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year. • Once the other plan processes the claim, then attach the original Explanation of Benefits (EoB) from that plan and complete this claim form.	

Member Certification & Authorization

I certify that the statements in this claim are true and complete and do not contain a claim for any expenses previously paid for by this or any other plan. I also certify that my covered family members, if applicable, meet the plan eligibility requirements. I authorize release of any information or record requested in respect of this claim to the Plan Administrator, Sun Life Assurance Company of Canada to be used for the limited and sole purposes of underwriting, administering and paying claims under the PDSP. The Plan Administrator may check the accuracy of the information given in support of this claim.

Member Signature	Date	Day	Month	Year
X		/	/	

Mail the completed form to:

Sun Life Assurance Company of Canada
Dental Claims Office
PO Box 9805 CSC-T (613) 247-5100 or
Ottawa ON K1G 6M6 1-888-757-7427 (toll-free in North America)