YOUNGSTENSTAR
EMPLOYEE GROUP BENEFIT SOLUTIONS

Dental Accident Report Form

SECTION A: *Claimant Information*

Employer Name		Group No.
Claimant Name		Date of Birth MM/DD/YYYY
Email	Certificate No.	Phone No.
Address		

SECTION B: *Accident Information*

Please describe the accident or the nature of the sickness/illness:

❑ **I've attached accident information**

Claimant's Certification: The above statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered without refund of any premiums paid. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Privacy Notice: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and coordinating coverage with other insurers. For these purposes existing insurance files about me, may be consulted along with additional information about and from me, and where required, collect information from and exchange information with, third parties. A claims file to which access will be restricted to authorized employees and agents of the Insurer and to persons authorized by law will be established. If I have the right to access the information, access will be given to me or such persons as I may authorize. I consent to the collection, use, and distribution of my personal information as may be required for these purposes as of the date of signing of this Claimant Statement and understand that such consent will remain in place until such time as I may revoke it.

Authorization: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Youngs-Ten Star Group Benefits Inc., or representatives thereof, all personal health information, benefit payment or financial information about the insured or any other information or records about the insured in its possession that is requested while administering this claim.

SECTION C: *Confirmation*

I hereby certify that a photocopy of this authorization shall be as valid as the original.

Claimant Signature:	Date: MM/DD/YYYY

SUBMIT THIS FORM ALONG WITH A STANDARD DENTAL CLAIM FORM COMPLETED BY THE DENTIST

Youngs-Ten Star Group Benefits Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business. Youngs-Ten Star's privacy policy can be viewed at www.youngstenstar.ca/privacy

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t. (905) 383-9616 tf. 1 (888) 833-0097 f. (289) 807-1984 a. 95 Hamilton St. North, Waterdown, ON L0R 2H0
e.info@youngstenstar.ca w. youngstenstar.ca