



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 FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.
	OFFICE VERIFICATION / DENTIST'S SIGNATURE

PART 2 MEMBER IDENTIFICATION			
MEMBER'S NAME _____	UNION ID _____		
MOST RECENT EMPLOYER _____	DATE OF BIRTH _____ / _____ / _____ DAY MONTH YEAR		
AUTHORIZATION AND SIGNATURE: I certify that, if this claim is being made on behalf of my Spouse and/or Dependents, I am authorized to disclose information about them, for the purposes of assessing and paying a benefit, if any. I certify that the information given is true, correct and complete to the best of my knowledge. I understand that this information will be protected pursuant to the relevant privacy legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Insurers, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.			
Please complete all of the above information. The claim will be returned if any information is missing.		SIGNATURE _____	

Privacy Statement: The Carpenters' Residential Benefit Plans (called "the Plans/Plan"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans/Plan or administrator will collect, maintain, use and disclose only the information that is necessary for the administration of the Plans/Plan. Personal information will be protected pursuant to the applicable legislation. The Plans/Plan may collect, maintain, use and disclose personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, reinsurers) in order to manage the Plans/Plan and entitlement to the benefits of the Plans/Plan, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer.