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8. If t	reatme	nt is a	dent	ure, crov	vn or bridge, is	it an i	nītiblop	ol āò æ	ment?						
If "	No," pr	ovide 1	the la	st place	ment date and i	reaso	n for r	eplac	emen	t					
9. Is	any tre	atmen	t requ	ired for	orthodontic Tp\\ o	p ās¥s	3								
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f this	claim i	nclude	s an a	amount (under my Health	n Spe	nding	Acco	unt, I c	ertif	y tha	it the	e amount qualifies as a	medical expense for i	ncome ta
or wh	om I a	m mak	ing a	claim ar	e eligible and in	clude	myse	If, my	spous	se a	nd a	ny d	ependents as defined u	ınder the Health Sper	ding Acc

Signature of Employee Date

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from whe medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also variety personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this

consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

INSTRUCTIONS (Please read carefully)

The Dentist completes part 1. The Employee completes part 2.

Please ensure all questions are answered or your claim may take longer to process.

Send completed claim form to:

Chambers of Commerce Group Insurance Plan

1051 King Edward Street

Winnipeg, MB R3H 0R4

Telephone 1-800-665-3365 • Fax 1-800-457-8410

WANT TO GET YOUR CLAIM PAID FASTER? SUBMIT YOUR CLAIMS ONLINE

- Go to www.my-benefits.ca and register for the Plan member secure site
- Sign up DdRECT DEPOSIT
- Submit claims onlise VE TIME, PAPER AND MONEY!
- Download our app from either Google Play or the Apple Store.