

(To be completed by the Teacher)

Important: If any information is missing or incomplete the claim will be returned

1. If crown or bridge, is this initial placement? Yes No
 If yes, send pretreatment x-rays.
 If no, date of prior placement _____ reason for replacement _____
year month day

If bridgework is initial placement, is patient wearing a partial denture, or ever had a partial denture? Yes No
 If yes, date of prior placement _____ reason for replacement _____
year month day

2. If denture, is this initial placement?
 Yes No
 If no, date of prior placement _____ reason for replacement _____
year month day

3. Is patient entitled to coverage under any other insurance or dental plan for these services listed on this claim?
 Yes No

Worker's Compensation Saskatchewan Government Insurance Medical Care Insurance Commission
 Other dental plan (identify) _____
 Other gov't program (identify) _____
 Spouse's plan: Employer _____ Insurance Carrier: _____

4. If claim is for dependent child, please provide spouse's birthdate: _____ and employee's birthdate: _____
year month day year month day

5. Has payment been made by any insurance or dental plan for services listed on this claim? Yes No
 If yes, attach a copy of reimbursement showing the procedures and amounts reimbursed.

6. This is a: claim for benefits estimate

A teacher is eligible if he/she has been employed on a contract of employment (Section 200 of *The Education Act*) for at least 20 occasions of teaching. Teachers receiving disability benefits under the STF Income Continuance Plan and / or the Teachers' Superannuation Plan are covered under the Plan. Teachers who have temporary or replacement contracts must have their school board authorize their dental claim.

I certify that I am currently teaching under contract with a Saskatchewan School Board and to the best of my knowledge am eligible for coverage under the Saskatchewan Teachers' Dental Plan.

I authorize the release of any information requested in respect of this claim to the Claims Administrator, or its agents, and certify that the information given is true, correct, and complete to the best of my knowledge. I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to the dentist/denturist for the entire cost of the treatment.

 Signature of teacher _____ Date

Part 3 - Employing School Division (To be completed if claim is for a temporary/replacement teacher)

I verify that the above temporary/replacement teacher qualifies for dental coverage. The contract termination date if known: _____
Date

 Employing School Division - Authorizing Signature _____ Date

Forward to the Teachers' Superannuation Commission after authorization.