IUOE Local 793

Dental Claim

Pension and Benefits
Administered by

A Introduction

➔ **Attach all original receipts** showing full name of patient, date of service, dental codes, and details of the procedures done.

Retain copies of your receipts for submission to any other benefits plan that you may have.

Please request, fill in, and return an updated Personal Information File (PIF) to notify OEBAC of any changes in information about: **(a)** you, the Plan Member; **(b)** your dependants; **(c)** any other health care plan that you or your dependants may have; **(d)** your beneficiaries; **(e)** your bank accounts; or **(f)** the individuals authorized to inquire about your benefits. By doing this on time, you will facilitate faster processing of your claims and reduce the chances of claim rejection.

B Plan Member's information

For office use only
ABCDEFGH

Full Name		From your OEBAC Benefits Card Group #: ☐ 793 ☐ 793X Certificate #:
Phone #	Email	Or, from your IUOE Local 793 Card Registration #:

C Claim information

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ABCDEFGH

Patient's Full Name	Amount Claimed	If treatment is due to an accident, please provide details

Is this claim related to a Motor Vehicle Accident (MVA)? ☐ Yes ☐ No

If the answer is "No":
I acknowledge that the foregoing true to the best of my knowledge and my claim for benefits may be subject to an audit requiring proof from my doctor confirming my claim is not related to a MVA (Motor Vehicle Accident).
Initial Box ☐

Do you want any unpaid balance from this claim reimbursed from your Health Care Spending Account (if eligible)? ☐ Yes ☐ No

D Signature

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By signing below,

- I solemnly declare that the information provided on this form is accurate to the best of my knowledge.
- I authorize IUOE Local 793, OEBAC, and any of its service providers to use and disclose the provided information and any other information collected about me, my Dependants, or my Beneficiaries to process my benefits, to obtain advice, and to manage the Health and Welfare, Group Legal, and Pension Benefits Plans.

Name of Plan Member	Signature of Plan Member	Date (yyyy-mm-dd)

Staple this form and all the attachments and mail them to

OEBAC
2201 Speers Rd., Unit 1
Oakville, ON L6L 2X9

or

Scan this form and the requested attachments (both sides if required) and email to
info@oebac.org