Great West Life Assurance Co.

EXPLANATION OF BENEFITS - PATIENT COPY

DENTIST: Michael A Robinson HBSc DDS
OFFICE CLAIM NO. 008736

VERIFICATION NO.
UNIQUE ID NO. 561097600
OFFICE NO. 254A

POLICY#: 44501
CERTIFICATE NO: 000393080
INSURED: Michael Jack BIRTHDATE Dec 16, 1972

DIVISION/SECTION NO:
DEPENDANT NO: 00 CARD NO: 0

PATIENT: Michael Jack BIRTHDATE Dec 16, 1972
RELATIONSHIP TO INSURED/MEMBER: Self

INSURANCE COMPANY CLAIM NUMBER: 8000847571

DATE SUBMITTED: Jan 08, 2009

PROC		TH#	DATE	CHARGE	ELIGIBLE	DEDUCT	AT	BENEFIT	NOTE
01205	Exam, Emergency*		Jan/08/2009	55.00	55.00	0.00	90%	49.50	
02111	1 PA		Jan/08/2009	27.59	22.59	0.00	90%	20.33	1

TOTAL BENEFIT TO INSURED: $ 69.83

Payee's Address: 1049 Primrose Lane

Peterborough ON K9J6X5

The information contained on this form has been used to process your claim electronically.
Please verify the accuracy of this data and report any discrepancies to your dental office.
Do not mail this form to the insurer/plan administrator.

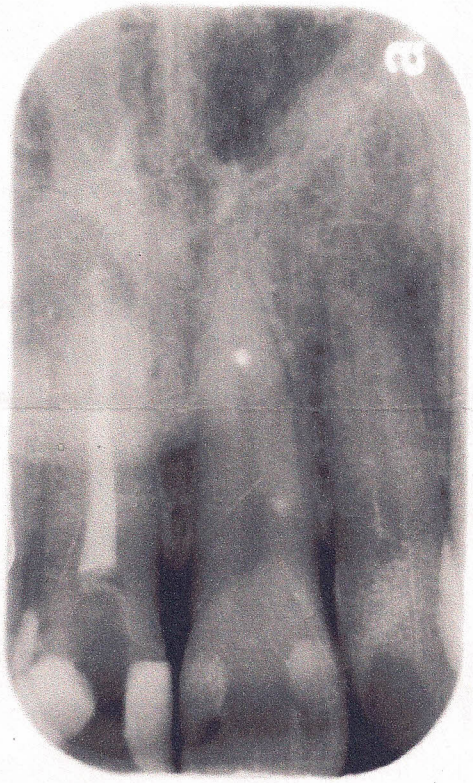
PATIENT INFORMATION:

1. Relationship to Subscriber: Self Date of Birth: Dec 16, 1972
If dependant, indicate: Student No Handicapped No
2. Are any Dental Benefits or services provided under any other group insurance or dental plan, WCB or gov't plan?
No
3. Is treatment resulting from an accident?No
4. If denture, crown or bridge, is this the initial placement? No
5. Is any treatment provided for orthodontic purposes? No

Notes:
01 WE CALCULATED YOUR BENEFIT USING THE FEE GUIDE SPECIFIED IN YOUR PLAN.
02 ** - IF YOU HAVE ANY QUESTIONS, PLEASE CALL GREAT-WEST LIFE.
03 ** - IN TORONTO: 440-0406. OUTSIDE TORONTO: 1-800-874-5899

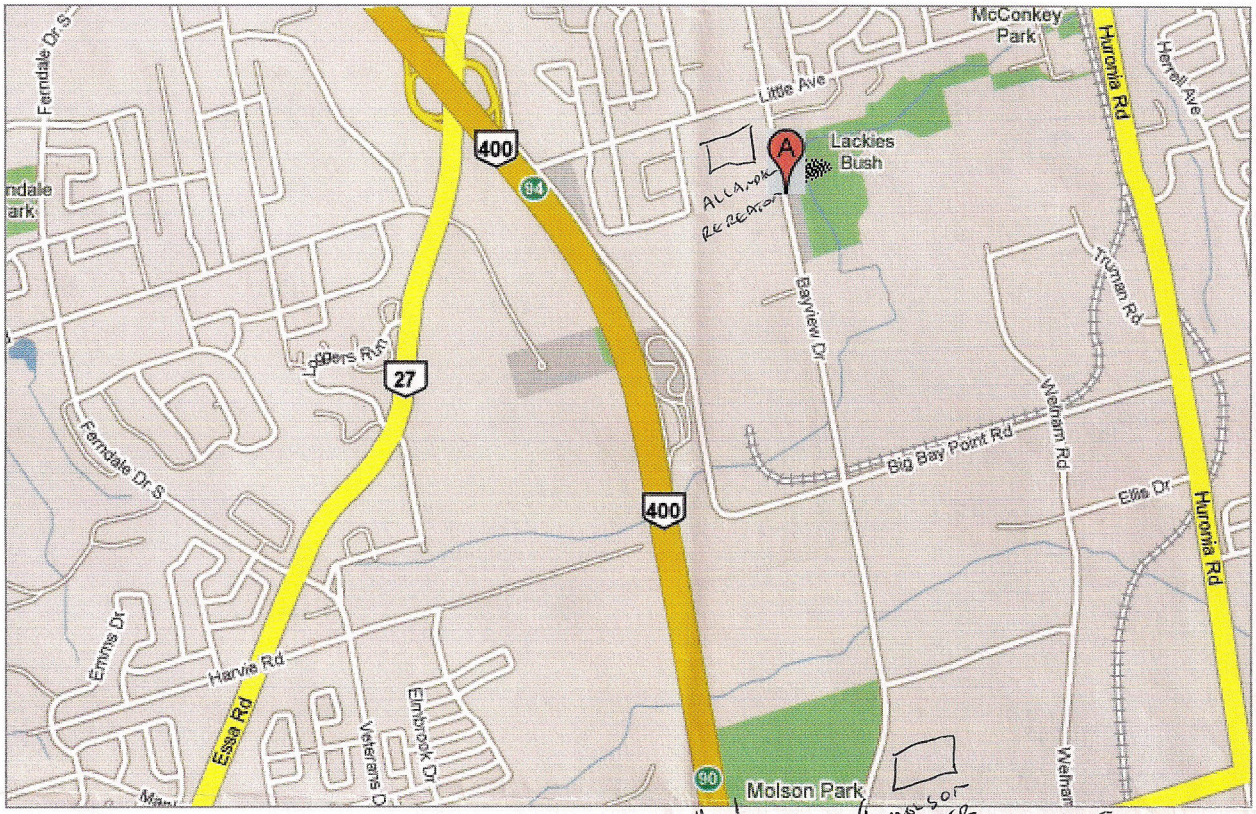
This Claim Has Been Submitted Electronically on Your Behalf By Your Dentist
Please Direct Any Inquiries to Your Insurer / Plan Administrator
Expenses Not Payable May be Considered for Income Tax Purposes
Please Retain Copy

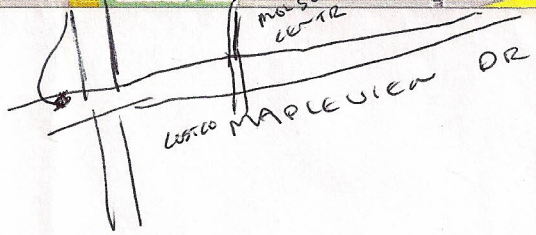
Patient: **Michael Jack** *Date:* **01/08/09**



Google Maps Canada

Results **1** - **1** of about **1** for **michael robinson dentist barrie**





A. **Robinson Michael** Dr
231 Bayview Drive, Barrie, ON L4N 4Y5 - (705) 737-2381

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2.10 - 2:20

BE THERE @ 2.00 IF POSSIBLE

Ontario Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO | SPEC | PATIENT'S OFFICE ACCOUNT NO

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

PLEASE PAY SUBSCRIBER

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME: Michael GIVEN NAME: Jack

ADDRESS | APT

CITY | PROV | POSTAL CODE

DENTIST

Dr. R. Bastian
238 Parkhill Rd. E.
Peterborough ON K9H 1R2
PHONE NO. 745-7361 0610227

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

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 CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
10	01	09	01205			38-		38-
10	01	09	02111			40-		40-

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED 78-

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO | DATE

DEDUCTIBLE | PATIENT PAYS | PLAN PAYS

CLAIM NO

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT. DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN, YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2, AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 — EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO. ____ DIVISION/SECTION NO. ____

EMPLOYER ____

NAME OF INSURING AGENCY OR PLAN ____

2. YOUR NAME (PLEASE PRINT) ____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. ☐☐☐☐☐☐☐☐☐

YOUR DATE OF BIRTH ____ DAY MONTH YEAR

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER ____
   DATE OF BIRTH ____ DAY MONTH YEAR
   IF CHILD INDICATE STUDENT ☐ HANDICAPPED ☐
   IF STUDENT, INDICATE SCHOOL ____
   PATIENT I.D. NO. ____
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO ☐ YES ☐
   POLICY NO. ____ SPOUSE DATE OF BIRTH ____
   NAME OF OTHER INSURING AGENCY OR PLAN ____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO ☐ YES ☐
4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT NO ☐ YES ☐
5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐
6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE ____ DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4 — POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE: DAY MONTH YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ENDODONTIC ASSOCIATES

ELIE M. WOLFSON, D.D.S.
WAYNE H. PULVER, D.D.S.
MARC M. FACTOR, D.D.S.

www.endodonticassociates.com

January 13th 2009

TO WHOM IT MAY CONCERN:

Re: Michael Jack

I saw Michael today and performed a partial root canal procedure and also a surgical procedure for him. I need to see Michael again to complete the root canal procedure in a couple of weeks.

Signed:

Dr. Wayne Pulver

159 Willowdale Avenue, Toronto, Ontario M2N 4Y7 • Tel.: (416) 222-9900 ~ 1-800-667-7668 Fax: (416) 222-9901
2100 Ellesmere Rd., Suite 333, Scarborough, Ontario M1H 3B7 • Tel.: (416) 439-4200 ~ 1-800-565-7668 Fax: (416) 439-4203
Mount Sinai Hospital, 600 University Avenue, Suite 412, Toronto, Ontario M5G 1X5 • Tel.: (416) 586-8518 Fax: (416) 586-4745
105 Main Street, Suite 3, Unionville, Ontario L3R 2G1 • Tel.: (905) 479-4333 Fax: (905) 479-2250

Great West Life Insurance

CLAIM ACKNOWLEDGEMENT

DATE: **CARRIER CLAIM NO:**

DISPOSITION:

CLAIM HAS BEEN ACCEPTED FOR FURTHER PROCESSING.

DENTIST: Endodontic Associates
ADDRESS: Wayne H. Pulver, D.D.S.
159 Willowdale Avenue,
Willowdale ONT M2N 4Y7

UNIQUE ID NO: 06075002000

TELEPHONE: (416) 222-9900

DENTAL OFFICE CLAIM REFERENCE NO: 44111

PATIENT: MICHAEL JACK 119449-1 **BIRTHDATE:** Dec 16 1972

POLICY: 44501 **DIVISION/SECTION:**

INSURED: MICHAEL JACK

ADDRESS: 1049 PRIMROSE LANE
RR #4
PETERBOROUGH ON K9J 6X5

CERTIFICATE NO: 0000393080

PROCEDURE		TOOTH	SURFACES	DATE	FEE	LAB	TOTAL
01204	Examination, Specific			Jan 13 2009	125.00		125.00
02111	Xray Interpretation-1			Jan 13 2009	25.00		25.00
75112	I & D Soft Tissue, Intra	12		Jan 13 2009	175.00		175.00

BENEFIT AMOUNT IS PAYABLE TO: INSURED **TOTAL SUBMITTED:** 325.00

STATUS: H-CLAIM RECEIVED SUCCESSFULLY BY CARRIER & HELD FOR PROCESSING.
THIS CLAIM HAS BEEN SUBMITTED ELECTRONICALLY - THIS IS A RECEIPT ONLY

STATEMENT

Endodontic Associates
Elie M. Wolfson, DDS,FRCD(C)
159 Willowdale Avenue
Willowdale ONT M2N 4Y7

Telephone: (416) 222-9900

MR MICHAEL JACK
1049 PRIMROSE LANE
RR #4
PETERBOROUGH ON K9J 6X5

Date	Account
01/13/2009	119449
	Remittance

IMPORTANT - PLEASE DETACH UPPER PORTION AND RETURN WITH YOUR REMITTANCE TO INSURE CREDIT TO PROPER ACCOUNT

Date	Patient	Description	Charges	Credits	Balance
		Previous Balance			0.00
01/13/2009	MICHAEL	Examination, Specific	125.00		125.00
01/13/2009	MICHAEL	Xray Interpretation-1	25.00		150.00
01/13/2009	MICHAEL	I & D Soft Tissue, Intra	175.00		325.00
01/13/2009	MICHAEL	Visa Payment		800.00	475.00-
		Incomplete Services			
	MICHAEL	Retreatment - 1 Canal	900.00		425.00
	MICHAEL	Root Canal/Two/Full Dev.	825.00		1,250.00

Account Total **1,250.00**

Your account is subject to a 1.5% per month (18% annual) finance charge after 30 days.

Current	30 Days	60 Days	90 Days	120+ Days
1,250.00	**0.00**	**0.00**	**0.00**	**0.00**

ENDODONTIC ASSOCIATES

ELIE M. WOLFSON, D.D.S.

WAYNE H. PULVER, D.D.S.

MARC M. FACTOR, D.D.S.

www.EndodonticAssociates.com

I understand that the fee for examination, X-ray interpretation, consultation and endodontic service for the following teeth # 11,12 is $ ____.

TOTAL FEE: $ 2050 -

This fee and my obligations have been discussed with me today.

Should I decide not to proceed with the treatment, I understand that there is a fee owing for the examination, X-ray interpretation and consultation which has been carried out.

Payment for services rendered is my responsibility and not that of any insurance company. Fees are based on the current year's Fee Guide for Specialists.

Payment is due as the work progresses and if not paid in full by completion of treatment, any unpaid balance will be subject to a service charge of 1% per month which is 12% annually.

Date: 1/15/09

Signature

Checked by

159 Willowdale Avenue, Willowdale, Ontario M2N 4Y7
Tel: (416) 222-9900 ~ 1-800-667-7668 Fax: (416) 222-9901

2100 Ellesmere Rd., Suite 333, Scarborough, Ontario M1H 3B7
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Mount Sinai Hospital, 600 University Ave., Suite 412 Toronto, Ontario M5G 1X5
Tel: (416) 586-8518 Fax: (416) 586-4745

105 Main Street, Suite 3, Unionville, Ontario L3R 2G1
Tel: (905) 479-4333 Fax: (905) 479-2250

40 Peel Centre Dr., Suite 119, Bramalea, Ontario L6T 4B4
Tel: (905) 792-2400

Great West Life Insurance

CLAIM ACKNOWLEDGEMENT

DATE: **CARRIER CLAIM NO:**

DISPOSITION:

CLAIM HAS BEEN ACCEPTED FOR FURTHER PROCESSING.

DENTIST: Endodontic Associates
ADDRESS: Wayne H. Pulver, D.D.S.
159 Willowdale Avenue,
Willowdale ONT M2N 4Y7

UNIQUE ID NO: 06075002000

TELEPHONE: (416) 222-9900

DENTAL OFFICE CLAIM REFERENCE NO: 44328

PATIENT: MICHAEL JACK 119449-1 2 **BIRTHDATE:** Dec 16 1972
POLICY: 44501 **DIVISION/SECTION:**
INSURED: MICHAEL JACK
ADDRESS: 1049 PRIMROSE LANE
RR #4
PETERBOROUGH ON K9J 6X5
CERTIFICATE NO: 0000393080

PROCEDURE		TOOTH	SURFACES	DATE	FEE	LAB	TOTAL
33115	Retreatment - 1 Canal	11		Jan 21 2009	900.00		900.00
33121	Root Canal/Two/Full Dev.	12		Jan 21 2009	825.00		825.00

BENEFIT AMOUNT IS PAYABLE TO: INSURED **TOTAL SUBMITTED:** 1,725.00

STATUS: H-CLAIM RECEIVED SUCCESSFULLY BY CARRIER & HELD FOR PROCESSING.
THIS CLAIM HAS BEEN SUBMITTED ELECTRONICALLY - THIS IS A RECEIPT ONLY

STATEMENT

Endodontic Associates
Elie M. Wolfson, DDS,FRCD(C)
159 Willowdale Avenue
Willowdale ONT M2N 4Y7

Telephone: (416) 222-9900

MR MICHAEL JACK
1049 PRIMROSE LANE
RR #4
PETERBOROUGH ON K9J 6X5

Date	Account
01/21/2009	119449
	Remittance

IMPORTANT - PLEASE DETACH UPPER PORTION AND RETURN WITH YOUR REMITTANCE TO INSURE CREDIT TO PROPER ACCOUNT

Date	Patient	Description	Charges	Credits	Balance
		Previous Balance			0.00
01/13/2009	MICHAEL	Examination, Specific	125.00		125.00
01/13/2009	MICHAEL	Xray Interpretation-1	25.00		150.00
01/13/2009	MICHAEL	I & D Soft Tissue, Intra	175.00		325.00
01/13/2009	MICHAEL	Visa Payment		800.00	475.00-
01/13/2009	MICHAEL	Ins Form submitted - Great West Life Insurance			
01/21/2009	MICHAEL	Retreatment - 1 Canal	900.00		425.00
01/21/2009	MICHAEL	Root Canal/Two/Full Dev.	825.00		1,250.00
01/21/2009	MICHAEL	Ins Form submitted - Great West Life Insurance			
01/21/2009	MICHAEL	Visa Payment		1,250.00	0.00

Account Total **0.00**

Your account is subject to a 1.5% per month (18% annual) finance charge after 30 days.

Current	30 Days	60 Days	90 Days	120+ Days
0.00	**0.00**	**0.00**	**0.00**	**0.00**

Dr. Chris McArthur
201 Aylmer St. N.
Peterborough, Ontario
K9J 3K3

Tel (705)743-6140
Fax (705)743-2566
info@farlowdentistry.com

ACCOUNT STATEMENT

Farlow and McArthur Dentistry

DAYS OWING	CURRENT	30-59	60-89	OVER 90	LAST PAYMENT
	223.90				23/DEC/08

Michael Jack
1049 Primrose Lane
Peterborough ON K9J 6X5

DATE	03/FEB/09
ACCOUNT ID	14043
PLEASE PAY	223.90
AMOUNT ENCLOSED	

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

RETAIN THIS PORTION FOR YOUR RECORDS

PAGE: 1 ACCOUNT ID: 14043 AS OF: 03/FEB/09 BALANCE FORWARD: 0.00

DATE	PATIENT	DESCRIPTION	CHARGE	PAYMENT		BALANCE
03/FEB/09	Michael	Tooth Coloured Restoration	111.95			111.95
		Tooth Coloured Restoration	111.95			223.90
	Michael has an appointment at 10:00am on Thu 12/FEB/09.					

PAID
Barb Taylor

www.farlowdentistry.com
email- info@farlowdentistry.com

	CURRENT	30-59	60-89	OVER 90	TOTAL	PLEASE PAY
ACCOUNT	223.90				223.90	223.90
				TOTAL OBLIGATION	223.90	

Great-West Life Assurance Co.

EXPLANATION OF BENEFITS - Patient Copy

DENTIST: **Dr. Chris McArthur**
DENTAL OFFICE CLAIM REFERENCE No. **027170**

UNIQUE ID No. **065571300**
OFFICE No. **0394**

POLICY#: **044501**
CERTIFICATE NO: **0000393080**
INSURED/MEMBER: **Michael Jack**
PATIENT: **Michael Jack**
RELATIONSHIP TO INSURED/MEMBER: **Self**
INSURANCE COMPANY CLAIM NUMBER: **8003445613**

DIVISION/SECTION NO:

BIRTHDATE: **Dec 16, 72**
BIRTHDATE: **19721216**

Date Submitted: **Feb 03 2009**

Procedure	Description	Th#	Date.	Charge	Eligible	Deduct	AT	Benefit
23111	Resto, Permanent Anterior, Bonded 1 surface	11	Feb/03/09	111.95	111.95	0.00	90%	100.76
23111	Resto, Permanent Anterior, Bonded 1 surface	12	Feb/03/09	111.95	111.95	0.00	90%	100.76

TOTAL DENTIST CHARGES: **223.90**
TOTAL PAYABLE TO Insured/Member: $ **201.52**

Payee's Address: **1049 Primrose Lane**

Peterborough ON K9J6X5

The information contained on this form has been used to process your claim electronically.
Please verify the accuracy of this data and report any discrepancies to your dental office.
Do not mail this form to the insurer/plan administrator.

PATIENT INFORMATION:

1. Relationship to Subscriber: **Self** Date of Birth: **19721216**
   \ If dependant, indicate: Student Handicapped If Student, Name of student's school:
2. Are any Dental Benefits or services provided under any other group insurance or dental plan, WCB or gov't plan?
   Yes- No- **X** If Yes: Policy No: Name of Insurer/Plan Administrator:
   Certificate No: Dependant No.: Insured/Member Date of Birth:
   Relationship of Patient:
3. Is any treatment required as the result of an accident? Yes- No- **X**
   If yes, give date and details separately.
4. Is any treatment provided for orthodontic purposes? Yes- No- **X**

NOTES:

**** - IF YOU HAVE ANY QUESTIONS, PLEASE CALL GREAT-WEST LIFE.**
**** - IN TORONTO: 440-0406. OUTSIDE TORONTO: 1-800-874-5899**
This Claim Has Been Submitted Electronically on Your Behalf By Your Dentist
Please Direct Any Inquiries to Your Insurer/Plan Administrator.
Expenses Not Payable May be Considered for Income Tax Purposes
Please Retain Copy