Ordre des dentistes du Québec

CLAIM TO THE COMPENSATION FUND

CLAIM FORM

The Board of Directors of the Ordre des dentistes du Québec has established a Compensation Fund intended to compensate an individual following the use, by a dentist, of a sum for purposes other than those for which it was entrusted to them.

To file a claim, please complete this form. If there is not enough space, you may attach additional pages.

It is important to include all documents supporting your claim (copies of the treatment plans, bills, checks, receipts, statements of account, etc.).

The claim form must be duly completed and signed before a person authorized to administer oaths (lawyer, notary or commissioner for oaths).

For further information, please contact the Ordre des dentistes du Québec:
Telephone: 514.875-8511 or 1.800.361-4887, ext. 2255
Email: indemnisation@odq.qc.ca.

*For more details, please consult the Regulation respecting the compensation fund of the Ordre des dentistes du Québec.

IMPORTANT INFORMATION

Please fill out all fields so that your claim can be processed.

CLAIMANT IDENTIFICATION

Title

☐ Mr. ☐ Mrs. ☐ Other: _____

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Email _____

Preferred method of communication: ☐ Mail ☐ Secured Email

Choose the option that describes your situation:

☐ I am the claimant

☐ I am submitting a claim on behalf of another person

Name of the person for whom you are submitting the claim: _____

Relationship to that person: _____

800, boul. René-Lévesque Ouest, bureau 1640
Montréal (Québec) H3B 1X9

514 875-8511 | 1 800 361-4887

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Ordre des dentistes du Québec

CLAIM TO THE COMPENSATION FUND

INFORMATION REGARDING THE DENTIST INVOLVED

First Name _____ Last Name _____

Name of the clinic where the services were provided _____

Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Email _____

DETAILS OF THE CLAIM

1. Indicate the amount claimed: $ _____ *(the amount claimed may not include any sum corresponding to damages related to harm, if applicable).*

2. When have you been informed that the dentist used the sum for purposes other than those for which it had been entrusted to them: _____
   YYYY/MM/DD

3. Please provide all details related to your claim *(in chronological order: appointment dates, treatment plans, nature of care received and to be received, dates and amounts given to the dentist as advances on fees, invoices and receipts, etc.)*:

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DETAILS OF THE CLAIM

4. Have you attempted to recover the amount claimed from the dentist involved, or initiated any other proceedings to recover this sum, *including a civil action before the Small Claims Division, the Court of Quebec, or the Superior Court?*
☐ Yes ☐ No

   If yes, please describe the steps taken and, if applicable, provide the court file number:

   _____

   _____

   _____

5. Have you received a partial reimbursement of the amount claimed? ☐ Yes ☐ No

   If yes, please indicate the amount received and the name of the person who made the reimbursement:

   _____

   _____

   _____

6. Have you signed a release in favor of the dentist involved? ☐ Yes ☐ No

   If yes, please attach a copy of this release.

7. Have you submitted a request for an investigation to the Syndic's Office of the Order? ☐ Yes ☐ No

8. Have you filed a request for account arbitration with the Order? ☐ Yes ☐ No

9. In connection with this claim, are you represented by a lawyer? ☐ Yes ☐ No

   If yes, please complete the following section:

   First and last name of your lawyer: _____

   Name of the law firm: _____

   Address: _____

   Telephone: _____ Mobile: _____

   Email: _____

SWORN DECLARATION

I, the undersigned, hereby declare under oath that the information provided in support of this claim is complete, authentic, and truthful, and that the content of the documents submitted is also complete, authentic, truthful, and consistent with the originals.

I understand and accept that any false or misleading statement or representation, or any falsified document submitted in support of my claim, shall be deemed not to meet the requirements of the Order and may result in the rejection of my claim.

THIS FORM MUST BE SIGNED AND DATED IN THE PRESENCE OF THE PERSON RECEIVING YOUR SOLEMN DECLARATION

_____ _____

Claimant's Signature Date

Solemnly declared before me at _____

This _____ day of _____ 20 _____

_____

Signature of the person authorized to administer the oath
(Lawyer, Notary, or Commissioner for Oaths)

_____

Name of the person acting in this capacity ***(in block letters)***

_____

(Official seal or professional card required) Official Seal – Permit Number

AUTHORIZATION FOR THE DISCLOSURE OF PERSONAL INFORMATION

I, the undersigned, _____, residing at _____

_____, authorize the Ordre des dentistes du Québec to collect, retain, use, and disclose all personal information concerning me and relating to the processing of my claim to the Compensation Fund, to any related proceedings, and, where applicable, to the exercise of its subrogatory remedies.

I acknowledge and accept that all information relating to this claim may be transmitted to the Syndic's Office of the Ordre des dentistes du Québec, if applicable.

Furthermore, I authorize any person holding personal information about me to disclose such information to the Ordre des dentistes du Québec, upon request and for the purposes of processing my claim or any judicial or other proceedings that the Ordre may undertake in the event of the payment of compensation.

Signed at _____, on _____

_____

Claimant's Signature

_____

Claimant's Name ***(in block letters)***

PLEASE

- ✓ Complete, print, and sign the claim form in the presence of a person authorized to administer oaths (lawyer, notary, or commissioner for oaths).
- ✓ Complete, print, and sign the authorization for the disclosure of personal information form.
- ✓ Send both forms, accompanied by all supporting documents for your claim:

By mail to:

Compensation Fund of the Ordre des dentistes du Québec

800, boulevard René-Lévesque Ouest, Office 1640

Montreal (Quebec) H3B 1X9

OR

By email to: indemnisation@odq.qc.ca