Ontario

MINISTRY OF PUBLIC AND BUSINESS SERVICE DELIVERY
Ministère des Services au public et aux entreprises

APOSTILLE
(Convention de La Haye du 5 Octobre 1961)

1. Country: / **Pays :** **Canada**

This public document / **Le présent acte public**

2. has been signed by / **a été signé par** [redacted]

3. acting in the capacity of / **agissant en qualité de** **Notary Public**

4. bears the seal / stamp of / **est revêtu du sceau / timbre de** **Notary Public**

Certified
Attesté

5. at / **à** **Toronto, Ontario**

6. the / **le** **2025-07-04**

7. by / **par** [redacted]

8. N° / **sous n°** [redacted]

9. Seal / stamp / **Sceau / timbre :**

10. Signature / Signature : [redacted]

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Willowgrove Dental
Willowgrove Square
Saskatoon, SK,

Tel: (Fax:
willowgr sktel.net

Detailed Receipt

Paid by:

Road
Saskatoon, SK

Payment Date:
Tuesday, Augus

Fold Here

Provider	Date of Service	Patient	Total Charge	Oustanding Invoice Balance	Patient Payment		Insurance Balance Due
n	8/		$50.00	$145.00	$145.00	$0.00	$0.00
	01204	EXAMINATION, SPECIFIC AND - $50.00					
	43281	REMOVAL OF FIXED PERIODON - $95.00					
					Total Balance Due	$0.00	$0.00

Payment of $145.00 has been received by Mastercard

Remaining Family Balances

Patient	$0.00
Insurance	$0.00

Thank You.

Upcoming *Appointments*	**Date**	**Time**

I certify that thi true
of the origi ocu
Date: of , 2025

Not

Willowgrove Dental
[redacted]grove Square
Saskatoon [redacted]
[redacted]
Tel: [redacted]
Fax: (306) [redacted]
willowgrove[redacted]k[redacted]

Account of:

[redacted]
[redacted] Road
Saskatoon, SK
[redacted]

Patient ID [redacted]

Billing Provider: [redacted]

Treatments Billed On: Tuesday, Aug[redacted]2023

Patien[redacted]

Treatment Date	Code	Description	Tooth	Surf	Fee
8/29/2023	01204	EXAMINATION, SPECIFIC AND			$50.00
8/29/2023	43281	REMOVAL OF FIXED PERIODON			$95.00
				Total	**$145.00**

Family Statement / Receipt

	Total
Previous Balance:	$0.00
Total This Billing:	$145.00
Service Charge:	$0.00
This Payment:	$0.00
Balance Due:	$145.00

Balance To Date: $145.00 Pay this amount

Thank You.

I certify th[redacted]
of [redacted]
[redacted]e: J[redacted]ument
[redacted]Ju[redacted]

[redacted]

Barrister, Solicitor and N[redacted]

UNIVERSITY OF SASKATCHEWAN
Student Dental Clinic
COLLEGE OF DENTISTRY
USASK.CA/DENTISTRY

Dental Clinic
University of Saskatchewan
[redacted]ggins Road
Saskatoon, [redacted]

Chart # [redacted]

[redacted]Reid Rd

Saskatoon, [redacted]
Canada

Date : Feb[redacted]024

Receipt # : [redacted]

Date	Audit #	Description	Amount
02/20/2024		Exam & Diagnosis, Permanent	73.00
02/20/2024		Bitewing, Four Images	34.00
02/20/2024		Periapical, Five Images	40.00
02/20/2024	[redacted]	[redacted]stercard	-147.00

[redacted] For Director, Clinical Affairs

THIS IS YOUR OFFICIAL RECEIPT
NO DUPLICATES ISSUED

I certify that this is a true copy
of the original document
Date: [redacted]

[redacted]

Barrister, Solicitor

[redacted]

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. [redacted] SPEC. PATIENT'S OFFICE ACCOUNT NO. [redacted]

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

PATIENT
[redacted] Reid Rd
Saskatoon Sl[redacted]

Claim # [redacted] 1/1

DENTIST
General Practice University Of Saska
Office Code: [redacted]
105 Wiggins Road
Saskatoon [redacted]
([redacted])

XXXXXXXXXXXXXXX
SIGNATURE OF SUBSCRIBER

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

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 $ 147.00 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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

A Maze
OFFICE VERIFICATION

[redacted] SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM

General Practice University Of Saskatchewan

DATE OF SERVICE DAY MO. YR.	PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SUR-FACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
20 02 2024	02115			40.00	0.00	40.00
20 02 2024	02144			34.00	0.00	34.00
20 02 2024	01103			73.00	0.00	73.00

FOR CARRIER USE
ALLOWED AMOUNT INC % PATIENT'S SHARE
CHEQUE NO. DATE
DEDUCTIBLE PATIENT PAYS PLAN PAYS
CLAIM NO.

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

TOTAL FEE SUBMITTED 147.00

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 X 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 X 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.

SIGNATURE OF EMPLOYEE/PLAN MEMBER SUBSCRIBER DATE DAY MONTH YEAR

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

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

4. CONTRACT HOLDER DATE DAY MONTH YEAR

I certify that this is a true copy of the original [redacted]
Dated this [redacted] day of [redacted], 2025

[redacted]
Barrister, Solicitor [redacted]

UNIVERSITY OF SASKATCHEWAN

Student Dental Clinic

COLLEGE OF DENTISTRY
USASK.CA/DENTISTRY

Dental Clinic
University of Saskatchewan
[illegible]ggins Road
Saskatoon, S[illegible]

Chart # [illegible]

[illegible]id Rd

Saskatoon, [illegible]
Canada

Date : Februar[illegible]24

Receipt # : [illegible]

Date	Audit #	Description	Amount
02/27/2024		Perio Maintenance Package	45.00
02/27/2024	130394	Mastercard	-45.00

[illegible]

Signature For Director, Clinical Affairs

THIS IS YOUR OFFICIAL RECEIPT
NO DUPLICATES ISSUED

I certify tha[illegible]opy
of th[illegible]ment
D[illegible]