Manulife Financial

Group Benefits Dental Claim

PART 1 - DENTIST LAST NAME	GIVEN NAME	UNIQUE NO.	SPEC.	PATIENT	'S OFFICE ACCT. NO.	
P		UNIQUE NU.	Gi EQ.	FAILENI	S STERE AUGT. NO.	
A T ADDRESS APT.		D E N T S				
Т	T PHONE NO.					
FOR DENTIST'S USE ONLY - FOR ADDITION PROCEDURES, OR SPECIAL CONSIDERATI	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.					
	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)					
DUPLICATE FORM	OFFICE VERIFICATION					
DATE OF SERVICE PROCEDURE INTL. TOOTH CODE CODE	TOOTH SURFACES DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES			
				WHEN A PROPOSED COURSE OF TREATMENT IS EXPECTED TO COST MORE THAN \$500, A TREATMENT PLAN MUST BE FILED WITH MANULIFE FINANCIAL GROUP BENEFITS. YOU WILL BE ADVISED OF THE BENEFITS PAYABLE UNDER THE GROUP PLAN BEFORE TREATMENT BEGINS.		
				PRE-TREATMENT	X-RAYS ARE	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. E & OE. TOTAL FEE SUBMITTED: \$ REQUIRED FOR SOME PROCEDURES (E.G. CROWNS AND BRIDGES).						
PART 2 - PLAN MEMBER INFORMATION						
1. PLAN CONTRACT NUMBER 2. PLAN MEMBER NAME						
PLAN SPONSOR PLAN MEMBER CERTIFICATE NUMBER						
NAME OF INSURANCE COMPANY	IRTH (DD/MMM/YYYY)					
SIGN UP FOR DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENTS						
RECEIVE YOUR CLAIM PAYMENTS UP TO 70% FASTER WITH DIRECT DEPOSIT AND ENJOY THE CONVENIENCE OF SEEING YOUR CLAIM STATEMENTS ONLINE.						
GO TO WWW.MANULIFE.CA/GROUPBENEFITS AND REGISTER FOR THE PLAN MEMBER SECURE SITE						
 ONCE YOU'VE REGISTERED, OR IF YOU'RE ALREADY REGISTERED, LOG INTO THE SECURE SITE AND SELECT DIRECT DEPOSIT FOR CLAIMS FROM THE MENU TO THE LEFT OF THE SCREEN 						
ENTER YOUR BANKING INFORMATION						
PART 3 - PATIENT INFORMATION						
1. PATIENT: RELATIONSHIP TO PLAN MEMBER			SPOUSE DATE OF BIRTH (DD/MMM/YYYY)			
	NAME OF IN	NAME OF INSURANCE COMPANY				
	HANDICAPPED					
IF CHILD, INDICATE	3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY.					
2. ARE ANY DENTAL BENEFITS OR SERVIC GROUP INSURANCE OR DENTAL PLAN. A WORKERS' COMPENSATION BOARD OR	PLACEMEN [®]	4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.				
PLAN CONTRACT NUMBER		5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC NO YES PURPOSES?				

PART 4 - PLAN MEMBER CONFIRMATION

I CERTIFY THAT I, MY SPOUSE AND/OR MY DEPENDANTS OF MINOR OR MAJOR AGE ("DEPENDANTS"), HAVE RECEIVED ALL GOODS OR SERVICES CLAIMED AND THAT THE INFORMATION PROVIDED FOR THIS CLAIM IS TRUE AND COMPLETE. <u>IAUTHORIZE</u> MANULIFE FINANCIAL ("MANULIFE") TO COLLECT, USE, MAINTAIN AND DISCLOSE PERSONAL INFORMATION RELEVANT TO THIS CLAIM ("INFORMATION") FOR THE PURPOSES OF GROUP BENEFITS PLAN ADMINISTRATION, AUDIT AND THE ASSESSMENT, INVESTIGATION AND MANAGEMENT OF THIS CLAIM ("PURPOSES"). <u>IAM AUTHORIZED</u> BY MY DEPENDANTS TO DISCLOSE AND RECEIVE THEIR INFORMATION, FOR THE PURPOSES. <u>IAUTHORIZE</u> ANY PERSON OR ORGANIZATION WITH INFORMATION, INCLUDING ANY MEDICAL AND HEALTH PROFESSIONALS, FACILITIES OR PROVIDERS, PROFESSIONAL REGULATORY BODIES, ANY EMPLOYER, GROUP PLAN ADMINISTRATOR, INSURER, INVESTIGATIVE AGENCY, AND ANY ADMINISTRATORS OF OTHER BENEFITS PROGRAMS TO COLLECT, USE, MAINTAIN AND EXCHANGE THIS INFORMATION WITH EACH OTHER AND WITH MANULIFE, ITS REINSURERS AND/OR ITS SERVICE PROVIDERS, FOR THE PURPOSES. <u>IAUTHORIZE</u> THE USE OF MY SOCIAL INSURANCE NUMBER ("SIN") FOR THE PURPOSES OF IDENTIFICATION AND ADMINISTRATION, IF MY SIN IS USED AS MY PLAN MEMBER CERTIFICATE NUMBER. <u>IAGREE</u> A PHOTOCOPY OR ELECTRONIC VERSION OF THIS AUTHORIZATION IS VALID. <u>IUNDERSTAND</u> THAT MANULIFE'S PRIVACY POLICY AND PRIVACY INFORMATION PACKAGE ARE AVAILABLE AT WWW.MANULIFE.CA/GROUPBENEFITS, OR FROM MY PLAN SPONSOR.

SIGNATURE OF PLAN MEMBER

DATE (DD/MMM/YYYY)

ANY INFORMATION PROVIDED TO OR COLLECTED BY MANULIFE IN ACCORDANCE WITH THIS AUTHORIZATION, WILL BE KEPT IN A GROUP BENEFITS HEALTH FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- MANULIFE EMPLOYEES, REPRESENTATIVES, REINSURERS, AND SERVICE PROVIDERS IN THE PERFORMANCE OF THEIR JOBS;
- · PERSONS TO WHOM YOU HAVE GRANTED ACCESS; AND

• PERSONS AUTHORIZED BY LAW.

YOU HAVE THE RIGHT TO REQUEST ACCESS TO THE PERSONAL INFORMATION IN YOUR FILE, AND, WHERE APPROPRIATE, TO HAVE ANY INACCURATE INFORMATION CORRECTED.

PART 5 - MAILING INSTRUCTIONS

PLEASE MAIL YOUR COMPLETED CLAIM FORM AND RECEIPTS TO THE APPROPRIATE ADDRESS.

IF YOU LIVE OUTSIDEMANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMSOF QUEBEC:P.O. BOX 1654, WATERLOO ON N2J 4W2

IF YOU LIVEMANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMSIN QUEBEC:P.O. BOX 5000, STATION B, MONTREAL QC H3B 4B5