Manulife Financial

Canadian Dental Association

Group Benefits Dental Care Expense

PATIENT

LAST NAME | FIRST NAME AND INITIAL

ADDRESS

CITY | PROV. | POSTAL CODE

DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

PHONE NO.

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

SIGNATURE OF EMPLOYEE

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

DUPLICATE FORM ☐

PRE-TREATMENT X-RAYS ARE REQUIRED FOR ESTIMATES/CLAIMS INVOLVING MAJOR DENTAL WORK.

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.

OFFICE VERIFICATION

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE OF SERVICE YYYY	MM	DD	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGE
TOTAL FEE SUBMITTED								

NS Group Claims Department
NB PO Box 1030 Stn Central
PE Halifax NS B3J 2X5
NL

QC Group Claims Department
C. P. 3888
Succ. Maison de la Poste
Montréal QC H3B 3L7

ON Group Claims Department
PO Box 4607
Toronto ON M5W 4Z3

AB Group Claims Department
MB PO Box 2592 Stn M
SK Calgary AB T2P 5P4
BC
YT
NT
NU

Plan Sponsor | Plan contract # | Plan Member certificate #

Plan Member – Last Name | First Name and Initial | Date of Birth (yyyy/mm/dd)

Plan Member – Address | No. | Street | City | Province | Postal Code

Patient – Last Name | First Name and Initial | Relationship | Date of Birth (yyyy/mm/dd)

1. Is the dependant working? ☐ No ☐ Yes or Is the dependant attending school? ☐ No ☐ Yes
2. Are benefits available from another group plan? ☐ No ☐ Yes If yes, please provide the following information _____ (Insurance Carrier Name) _____ (Plan contract #)
3. If other coverage was available and has recently terminated, please provide termination date _____ (yyyy/mm/dd)

   The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Manulife Financial with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.
4. If for denture, bridge, crown or onlay/inlay, is this an initial placement? ☐ No ☐ Yes
   If yes, please provide date(s) teeth were extracted and all other missing teeth in arch _____ (yyyy/mm/dd)
5. If replacement, please provide date of prior placement and reason for replacement _____ (yyyy/mm/dd) Reason _____
6. If treatment is due to an accident, indicate date of accident _____ (yyyy/mm/dd)

7. Do you want any unpaid balance from this claim reimbursed from your **Health Care Spending Account?** (If Eligible) ☐ No ☐ Yes

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. **I authorize** 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"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** 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. **I authorize** 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. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my Plan Sponsor.

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.

Plan Member's Signature: _____ **Date:** _____