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Group Benefits Dental Claim

PART 1 - DENTIST								
LAST NAME	GIVEN NAME	UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCT. NO.				
P								
A T ADDRESS	APT.	D E						
i		N .						
N CITY PROV.	POSTAL CODE	T 						
T T	1 001/12 0052	S T PHONE NO.						
FOR DENTIST'S USE ONLY - FOR ADDITIONAL IN	NFORMATION, DIAGNOSIS,	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.						
PROCEDURES, OR SPECIAL CONSIDERATION.		SIGNATURE OF						
		PLAN MEMBER 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	(PARENT/GUARDIAN)					
DUPLICATE FORM		OFFICE VERIFICATION						
DATE OF SERVICE PROCEDURE INTL.	тоотн	LABORATORY						
DAY MO. YR. CODE CODE S	SURFACES DENTIST'S FEE	CHARGE	CHARGES	ECK HERE IF TREATMENT PLAN				
				PROPOSED COURSE OF				
				TENT IS EXPECTED TO COST HAN \$500, A TREATMENT PLAN				
				E FILED WITH MANULIFE IAL GROUP BENEFITS, YOU				
				ADVISED OF THE BENEFITS				
				E UNDER THE GROUP PLAN TREATMENT BEGINS.				
			PRE-TRI	EATMENT X-RAYS ARE				
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED TOTAL FEE CLIPALITIES. 6 (E.G. CROWNS AND BRIDGES).								
AND THE TOTAL FEE DUE AND PAYABLE, E & OE. TOTAL FEE SUBMITTED: \$								
PART 2 - PLAN MEMBER INFORMATI	ION							
1. PLAN NO ACC	OUNT/DIVISION NO	2. YOUR NAME (PLEAS	E PRINT)					
PLAN SPONSOR								
	Manulife Financial							
NAME OF INSURANCE COMPANY Manulife Financial YOUR DATE OF BIRTH (DD/MMM/YYYY) PART 3 - PATIENT INFORMATION								
1. PATIENT: RELATIONSHIP TO PLAN MEMBER		SPOUSE DATE OF E	IDTH (DD/MMM/VVV)	-				
		SPOUSE DATE OF BIRTH (DD/MMM/YYYY) NAME OF INSURANCE COMPANY						
TANKE OF INSURANCE COME AND								
DATE OF BIRTH (DD/MMM/YYYY)								
IF CHILD, INDICATE STUDENT	HANDICAPPED	AN ACCIDENT? IF YES, GIVE DATE AND DETAILS NO YES						
IF STUDENT, INDICATE SCHOOL		SEPARATELY.						
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED	TINDER ANY ——————	4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND						
OTHER GROUP INSURANCE OR DENTAL PLAN. ANY T		REASON FOR REPLA						
WORKERS' COMPENSATION BOARD OR GOV'T PLAN		5. IS ANY TREATMENT PURPOSES?	5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC NO YES					
PART 4 - PLAN MEMBER CONFIRMA	TION	FUNFOSES!						
I CERTIFY THAT THE INFORMATION IN THIS FORM IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY HEALTH CARE PROVIDER,								
OTHER INSURANCE COMPANY, ANY TYPE OF WORKERS' COMPENSATION BOARD, MY PLAN SPONSOR, OR OTHER PERSONS TO RELEASE AND EXCHANGE INFORMATION REQUESTED BY MANULIFE FINANCIAL, WHEN THE INFORMATION IS NEEDED TO PROCESS THIS CLAIM. IF MY SOCIAL INSURANCE NUMBER IS								
USED AS MY CERTIFICATE NUMBER, I AUTHORIZE ITS USE FOR THE IDENTIFICATION AND ADMINISTRATION OF MY GROUP BENEFITS. I AGREE THAT A								
PHOTOCOPY OF THIS AUTHORIZATION SHALL	BE AS VALID AS THE ORIGINAL.		D/	ATE (DD/MMM/YYYY)				
SIGNATURE OF PLAN MEMBER			U.					

AT MANULIFE FINANCIAL, WE KNOW THAT CONFIDENTIALITY OF PERSONAL INFORMATION IS IMPORTANT. ANY INFORMATION YOU PROVIDE TO US WILL BE KEPT IN A GROUP LIFE AND HEALTH BENEFITS FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- OUR EMPLOYEES AND SERVICE REPRESENTATIVES 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, IF NECESSARY, CORRECT ANY INACCURATE INFORMATION.

PART 5 - MAILING INSTRUCTIONS

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

MANULIFE FINANCIAL GROUP DENTAL CLAIMS PO BOX 1654 WATERLOO ON N2J 4W2