Manulife Financial

Dental Claim

PART 1 - DENTIST

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

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

PHONE NO.

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

☐ DUPLICATE FORM

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

SIGNATURE OF PLAN MEMBER/EMPLOYEE ▶

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

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED: $

☐ **CHECK HERE IF TREATMENT PLAN**

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 REQUIRED FOR SOME PROCEDURES (E.G. CROWNS AND BRIDGES).

PART 2 - PLAN MEMBER/ EMPLOYEE INFORMATION

1. GROUP/PLAN NO. _____ ACCOUNT/DIVISION NO. _____

PLAN SPONSOR/EMPLOYER _____

NAME OF INSURANCE COMPANY **Manulife Financial**

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERTIFICATE NO. _____

YOUR DATE OF BIRTH (DD/MMM/YYYY) _____

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO PLAN MEMBER/EMPLOYEE

_____

DATE OF BIRTH (DD/MMM/YYYY) _____

IF CHILD, INDICATE ☐ STUDENT ☐ HANDICAPPED

IF STUDENT, INDICATE SCHOOL _____

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

GROUP/PLAN NO. _____

SPOUSE DATE OF BIRTH (DD/MMM/YYYY) _____

NAME OF INSURANCE COMPANY

_____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. ☐ NO ☐ 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 ☐ YES

PART 4 - PLAN MEMBER/EMPLOYEE CONFIRMATION

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, WORKERS' COMPENSATION BOARD, MY EMPLOYER, 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.

SIGNATURE OF PLAN MEMBER/EMPLOYEE **DATE (DD/MMM/YYYY)**

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 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 APPROPRIATE ADDRESS.

IF YOU LIVE OUTSIDE OF QUEBEC:
MANULIFE FINANCIAL GROUP BENEFITS
DENTAL CLAIMS
P.O. BOX 1654
WATERLOO ON N2J 4W2

IF YOU LIVE IN QUEBEC:
MANULIFE FINANCIAL GROUP BENEFITS
DENTAL CLAIMS
P.O. BOX 5000, STATION B
MONTREAL, QC H3B 4B5