Manulife Financial

Group Benefits Dental Claim

PART 1 - DENTIST

PATIENT

LAST NAME	GIVEN NAME
DEPARTMENT/BRANCH NAME	DELIVERY STATION/BRANCH NUMBER

IF HOME DELIVERY IS DESIRED, PLEASE PROVIDE YOUR MAILING ADDRESS

CITY PROV. POSTAL CODE

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

DENTIST

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 ▶

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 $500.00, A TREATMENT PLAN MUST BE FILED WITH MANULIFE 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 INFORMATION

1. PLAN NO. **961216** ACCOUNT NO. _____
   PLAN SPONSOR **IBEW LOCAL 894**
   NAME OF INSURANCE COMPANY **Manulife Financial**

2. YOUR NAME (PLEASE PRINT) _____
   YOUR CERTIFICATE NO. OR SIN _____
   YOUR DATE OF BIRTH (DD/MMM/YYYY) _____

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO PLAN MEMBER _____

   DATE OF BIRTH (DD/MMM/YYYY) _____

   IF CHILD, INDICATE ☐ STUDENT ☐ DISABLED

   IF STUDENT, INDICATE SCHOOL _____

   PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, ANY TYPE OF WORKERS' COMPENSATION BOARD OR GOV'T PLAN ☐ NO ☐ YES

   PLAN NO. _____

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

NAME OF OTHER 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

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 PLAN MEMBER

_____ _____
DATE (DD/MMM/YYYY)

PART 4 - MAILING INSTRUCTIONS *Please place your completed claim form in an envelope and mail to:*

IBEW LOCAL 894
380 LAKE ROAD, UNIT 3
BOWMANVILLE ON L1C 4P8

PART 5 - PLAN MEMBER CONFIRMATION

I CERTIFY THAT THE INFORMATION IN THIS FORM IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND DOES NOT CONTAIN A CLAIM FOR ANY EXPENSES PREVIOUSLY PAID FOR BY ANY PLAN.

I AUTHORIZE ANY PERSON OR ORGANIZATION WHO HAS INFORMATION PERTAINING TO THIS CLAIM, INCLUDING ANY HEALTH CARE PROVIDER, INSURANCE COMPANY, ANY TYPE OF WORKERS' COMPENSATION BOARD, INVESTIGATIVE AGENCIES AND MY PLAN SPONSOR, TO RELEASE AND EXCHANGE SUCH INFORMATION REQUESTED BY MANULIFE FINANCIAL AND/OR ITS CLAIMS SERVICE PROVIDERS FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

I AUTHORIZE MANULIFE FINANCIAL AND ITS CLAIMS SERVICE PROVIDERS TO COLLECT, TO USE AND TO EXCHANGE WITH THE PERSONS OR ORGANIZATIONS LISTED ABOVE ANY INFORMATION NEEDED FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

IF THIS CLAIM IS MADE ON BEHALF OF MY SPOUSE AND/OR DEPENDANTS, I AM AUTHORIZED TO DISCLOSE INFORMATION ABOUT THEM, FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING 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 OR ELECTRONIC VERSION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

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.

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

PART 6 - INQUIRIES

Inquiries can be directed through the Manulife website www.manulife.com or 1-800-268-6195.