Manulife Financial

For your future™

# BAC - Canada
# Union Local No. 2 (Ontario)
# Employee Benefit Trust

Canadian D
Association

**YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL**

## PART 1 - DENTIST

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

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

SIGNATURE OF SUBSCRIBER

PATIENT: LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST: PHONE NO.

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

DUPLICATE FORM ☐

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

**TOTAL FEE SUBMITTED: $**

### INSTRUCTIONS

**IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.**

ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANI FLUORIDE TREATMENTS, X-RAYS, BASIC RESTORATIO AND EMERGENCY TREATMENT MAY BE PERFORMED B YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM F PREDETERMINATION OF BENEFITS.

X-RAYS MAY BE REQUIRED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURN PROMPTLY TO YOUR DENTIST.

## PART 2 - PLAN MEMBER *(Complete this part before taking the form to your dentist's office)*

1. PATIENT: RELATIONSHIP TO PLAN MEMBER _____
   DATE OF BIRTH (DD/MMM/YYYY) _____
   IF CHILD, INDICATE ☐ FULLTIME STUDENT ☐ HANDICAPPED
   DATE ENROLLED _____
   DATE COMPLETED _____
2. **DO YOU HAVE ANOTHER PLAN THAT PROVIDES HEALTH OR DENTAL BENEFITS FOR YOU OR YOUR DEPENDANTS?** ☐ **NO** ☐ **YES**
   ☐ **HEALTH ONLY** ☐ **DENTAL ONLY** ☐ **BOTH**
   **IF YES, IS THE OTHER COVERAGE PROVIDED THROUGH:**
   ☐ **MANULIFE FINANCIAL** ☐ **ANOTHER INSURER**
   **IF MANULIFE FINANCIAL, INDICATE POLICY NUMBER** _____
   **IF CLAIM IS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH** _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
   GIVE DATE AND DETAILS
4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES
   IS ANY TREATMENT FOR TMJ PURPOSES? ☐ NO ☐ YES
5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES
   IF INITIAL PLACEMENT ADVISE DATE TEETH WERE EXTRACTED _____
   AND ALL OTHER MISSING TEETH IN ARCH _____
   IF REPLACEMENT GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ NO ☐ YES
7. HAVE YOU TERMINATED YOUR EMPLOYMENT WITH THE EMPLOYER PROVIDING THESE DENTAL BENEFITS? IF SO, WHEN ____/____/____ (DAY / MONTH / YEAR)
8. PLAN MEMBER'S I.D. _____
   PLAN MEMBER'S DATE OF BIRTH ____/____/____ (DAY / MONTH / YEAR)
9. CONTRACT NO. 4386 - 01 - 000
   CONTRACTHOLDER AND LOCATION
10. I certify that I, my spouse and/or my dependants of minor or major age ("Dependants") received all goods or services claimed and that the information provided for this claim is tr complete. I authorize Manulife Financial ("Manulife") and/or its authorized representative to use, maintain and disclose personal information relevant to this claim ("Information") purposes of Group Benefits plan administration, audit and the assessment, investigati management of this claim ("Purposes"). I am authorized by my Dependants to disclose and their information for the Purposes. I authorize any person or organization with infor including any medical and health professionals, facilities or providers, professional reg bodies, any employer, group plan administrator, insurer, investigative agency, ar administrators of other benefits programs to collect, use, maintain and exchange this info with each other and with Manulife and/or its authorized representative, its reinsurers an service providers, for the Purposes. I authorize the use of my Social Insurance Number ("S the purposes of identification and administration, if my SIN is used as my plan member ce number. I agree a photocopy or electronic version of this authorization is valid. I understa Manulife's Privacy Policy and Privacy Information Package are availab www.manulife.ca/groupbenefits, or from my plan administrator.

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

    Any information provided to or collected by Manulife and/or its authorized representa accordance with this authorization, will be kept in a Group Benefits health file. Access information will be limited to:
    - Manulife employees, authorized 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, appropriate, to have any inaccurate information corrected.

    PLAN MEMBER'S NAME: _____ (PLEASE PRINT)
    ADDRESS: _____

Date _____ Signature of Plan Member _____ Telephone Number _____

Date _____ Signature of Spouse if claim is to be coordinated with another Manulife Financial Plan

Please mail form to:
GLOBAL BENEFITS
88 St. Regis Crescent South
Toronto, ON M3J 1Y8
Tel: (416) 635-6000