Manulife Financial

Canadian Dental Association

Dental Expense Claim

Possession of this claim form does not constitute eligibility for benefits

CLAIMS PROCESSED BY EMPLOYEE BENEFIT PLAN SERVICES - see below for submission instruction

PART 1 DENTIST

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

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

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NUMBER

SIGNATURE OF MEMBER

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

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)

DUPLICATE FORM ☐

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 THIS TOTAL FEE DUE AND PAYABLE E & OE

TOTAL FEE SUBMITTED

SUBMIT CLAIM FORM TO:

EMPLOYEE BENEFIT PLAN SERVICES
45 McIntosh Drive
Markham, Ontario,
L3R 8C7
(905) 946-9700
1-800-263-3564

PART 2 MEMBER — COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

GROUP POLICY No. 901902 LABOURERS' LOCAL 493 BENEFIT TRUST FUND

1. Plan member's name _____ (First / Initial / Last) Social Insurance No. ☐☐☐☐☐☐☐☐☐
2. Plan member's date of birth ____/____/____ (Day / Month / Year) Employee/Certificate No. (if applicable) _____
3. Is this your first claim with Manulife Financial? ☐ No ☐ Yes
4. Address _____ (Street / City/Town / Province / Postal Code)
5. **Are dental benefits payable for this claim from any other company or source? ☐ No ☐ Yes**
   If 'Yes' name company or source _____
6. a) If denture, bridge or crown, is this an initial placement? ☐ No ☐ Yes
   b) If initial placement, please advise date teeth were extracted and all other missing teeth in arch: _____
   c) If replacement, give date of prior placement and reason for replacement: _____
7. Which family member are these expenses being claimed for? _____ (Name) Is this family member the (check one) ☐ Employee ☐ Spouse ☐ Son ☐ Daughter

If this family member is a spouse or child, complete the following information:

8. Dependant's date of birth ____/____/____ (Day / Month / Year)
9. Is this dependant working? ☐ No ☐ Yes Is this dependant attending school? ☐ No ☐ Yes
   If 'YES' give name of employer or school _____
10. If treatment is due to an accident, indicate date of accident and details _____

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") and/or its authorized representative 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 and/or its authorized representative, 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 administrator.

Plan Member's Signature Date

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