Manulife Financial

Group Benefits 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 ▶

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 INFORMATION

1. PLAN CONTRACT NUMBER 86397

PLAN SPONSOR Teva Canada Limited

NAME OF INSURANCE COMPANY **Manulife Financial**

2. PLAN MEMBER NAME (PLEASE PRINT)

PLAN MEMBER CERTIFICATE NUMBER

DATE OF BIRTH (DD/MMM/YYYY)

HCSA CONTRACT NUMBER 86398

☐ REIMBURSE ANY UNPAID PORTION OF THIS CLAIM FROM MY HEALTH CARE SPENDING ACCOUNT (HCSA). (IF THE PATIENT HAS DENTAL COVERAGE UNDER ANOTHER PLAN, YOU **MUST** SUBMIT ANY UNPAID AMOUNT FROM THIS CLAIM TO THAT PLAN **BEFORE** USING YOUR HCSA.)

☐ ASSIGN THE PAYMENT FROM MY HCSA TO THE DENTIST.

SIGN UP FOR DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENTS

RECEIVE YOUR CLAIM PAYMENTS UP TO 70% FASTER WITH DIRECT DEPOSIT AND ENJOY THE CONVENIENCE OF SEEING YOUR CLAIM STATEMENTS ONLINE.

- GO TO WWW.MANULIFE.CA/GROUPBENEFITS AND REGISTER FOR THE PLAN MEMBER SECURE SITE
- ONCE YOU'VE REGISTERED, OR IF YOU'RE ALREADY REGISTERED, LOG INTO THE SECURE SITE AND SELECT **DIRECT DEPOSIT FOR CLAIMS** FROM THE MENU TO THE LEFT OF THE SCREEN
- ENTER YOUR BANKING INFORMATION

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO PLAN MEMBER

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. ANY TYPE OF WORKERS' COMPENSATION BOARD OR GOV'T PLAN ☐ NO ☐ YES

PLAN CONTRACT NUMBER

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

Please complete both pages of this form.

PART 4 - PLAN MEMBER CONFIRMATION

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") 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, 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 SPONSOR.

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

ANY INFORMATION PROVIDED TO OR COLLECTED BY MANULIFE IN ACCORDANCE WITH THIS AUTHORIZATION, WILL BE KEPT IN A GROUP BENEFITS HEALTH FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- MANULIFE EMPLOYEES, 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.

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

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