Manulife Financial

Dental Claim

To be completed by the plan member unless otherwise indicated.
Please retain copies for your files as original receipts/forms will not be returned.

1 Plan member/ Employee information

You can obtain your plan/group no., account/division no. and your certificate no. from your I.D. card.

Plan/Group no.	Acct./Div. no.	Certificate no.	Plan sponsor/Employer

Plan member/Employee name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

Plan member/Employee address (number, street and apt.)	City or town	Province	Postal code

Patient's name	Date of birth (dd/mmm/yyyy) (1st claim only)	Relationship to plan member (1st claim only)	Complete if patient is a student 18 or older: School and city	Complete if patient is a student 18 or older: If employed, hrs worked per week

Are you, your spouse or dependents covered under any other plan for the expenses being claimed?

◯ Yes ◯ No

If "Yes," please retain photocopies of all receipts/forms submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan/group no.	Spouse's certificate no.

Are these expenses eligible for coverage under workers' compensation? ◯ Yes ◯ No

Dental Accident

Are any of the services provided as the result of an accident?

◯ Yes ◯ No If "Yes," please explain when, where and how the injury occurred.

Orthodontic

Is any treatment for orthodontic purposes? ◯ Yes ◯ No

Denture/Bridge/Crown

If claim is for **denture, bridge or crown,** indicate if it is the initial placement or replacement and provide additional information where requested.

Initial placement Please give date(s) teeth were extracted for denture or bridge.	**Replacement** Please give date of prior placement and reason for replacement of the denture, bridge or crown.	
Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy)	Reason

2 Claims confirmation

I certify that all goods or services being claimed have been received by me/my dependents.

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.

Please sign here

Signature of plan member/employee	Date signed (dd/mmm/yyyy)

Please see reverse

Manulife Financial

MANULIFE FINANCIAL
GROUP DENTAL CLAIMS
PO BOX 1654
WATERLOO ON N2J 4W2

Please place your completed claim form in an envelope and mail it to this address.

To be completed by Dentist

Dental Claim

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 D	M	Y	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: $

PREDETERMINATION OF BENEFITS

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).

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.