Manulife

Affinity Markets
Assignment of Benefits

IMPORTANT NOTE: Complete this form only when assigning benefits to the provider. A separate Assignment of Benefits form must be completed for each provider.

1 Plan member information

Plan number

Identification number

Plan member name (first, middle initial, last)

Date of birth (dd/mmm/yyyy)

Address (number, street and apartment)

City/Town | Province | Postal code | Telephone number ( )

2 Provider information

Provider name

Address (number, street and suite)

City/Town | Province | Postal code | Telephone number ( ) Ext.

Provider registration number

Provider signature or official stamp

Date (dd/mmm/yyyy)

3 Authorization

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 the service provider for the entire cost associated with this claim.
I hereby assign my benefits payable from this claim to the named service provider and authorize payment directly to them.

I understand that Manulife and/or a Benefit Plan Sponsor reserve the right to modify assignment privileges for specific benefits, benefit categories, specific service providers or service provider categories.

I/We hereby certify that the information provided in connection with this claim is true, accurate and complete.
I/We hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medically related facility, pre-payment organization, insurance company, third party administrator, plan sponsor, employer, government agency, investigative or security agency or any other person or organization having any records, knowledge or information concerning this claim or my/our health or the health of any insured member of my/our family as it may relate to this claim to release such information to Manulife to exchange such information with any of the named parties where such exchange is necessary for the proper adjudication and processing of the claim. A photocopy of this signed authorization shall be as valid as the original.

Please sign and date here.

Signature of plan member

Date signed (dd/mmm/yyyy)

At Manulife, we know that confidentiality of personal information is important. Any information you provide to us will be kept in an Affinity Markets 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. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, PO Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6.
A copy of our privacy principles and practices is available for view at **manulife.ca**.

4 Mailing instructions

Please mail your form to the following address:

Manulife Affinity Markets
Health Claims
PO BOX 4214, STATION A
TORONTO ON M5W 5M4

5 Questions?

We're here to help!
Should you have any questions on this form, please feel free to contact us:

Phone:
Toll Free 1-800-268-3763
(Monday - Friday, 8am - 8pm ET)

Email:
more_info@manulife.com