Manulife

Consumer Markets Dental Claim

PART 1 - DENTIST

PATIENT

LAST NAME	GIVEN NAME	UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NUMBER

ADDRESS APARTMENT

CITY PROVINCE POSTAL CODE

DENTIST

PHONE NUMBER

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

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) ▶

☐ DUPLICATE FORM

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INITIAL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

☐ **CHECK HERE IF TREATMENT PLAN**

WHEN A PROPOSED COURSE OF TREATMENT IS EXPECTED TO COST MORE THAN $500, IT IS RECOMMENDED THAT A TREATMENT PLAN BE FILED WITH MANULIFE CONSUMER MARKETS. PRE-TREATMENT X-RAYS ARE REQUIRED FOR SOME PROCEDURES (E.G. CROWNS AND BRIDGES).

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

TOTAL FEE SUBMITTED: $

PART 2 - PLAN MEMBER INFORMATION

1. PLAN NUMBER _____

NAME OF INSURANCE COMPANY **Manulife**

2. YOUR NAME (PLEASE PRINT) _____

YOUR TELEPHONE NUMBER ( )

YOUR IDENTIFICATION NUMBER _____

YOUR DATE OF BIRTH (DD/MMM/YYYY) _____

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 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

BY SUBMITTING A CLAIM TO MANULIFE, I CONFIRM THAT I UNDERSTAND AND AGREE TO ALL OF THE FOLLOWING:

I CERTIFY THAT THE INFORMATION PROVIDED FOR THE CLAIM(S) BEING SUBMITTED IS TRUE, ACCURATE AND COMPLETE AND THAT I, MY SPOUSE OR CO-APPLICANT AND/OR MY DEPENDENTS HAVE RECEIVED ALL GOODS OR SERVICES OR QUALIFY FOR BENEFITS AS CLAIMED. **I UNDERSTAND AND ACKNOWLEDGE** THAT SUBMISSION OF A CLAIM DETERMINED BY MANULIFE TO BE FALSE OR MISREPRESENTED MAY RESULT IN COVERAGE BEING RESCINDED BY MANULIFE WITHOUT FURTHER NOTICE. **I UNDERSTAND AND ACKNOWLEDGE** THAT MANULIFE MAY REFER ANY CLAIMS IT HAS DETERMINED WERE FALSELY SUBMITTED TO LAW ENFORCEMENT AUTHORITIES FOR POSSIBLE PROSECUTION AND MAY PURSUE THE RECOVERY OF ANY MONEY OBTAINED IMPROPERLY THROUGH FALSE CLAIM SUBMISSION. **I ALSO AGREE** TO REFUND ANY MONIES OR OVERPAYMENTS THAT I MAY OWE TO MANULIFE IN ACCORDANCE WITH THE PROVISIONS OF MY COVERAGE AND **I AUTHORIZE** MANULIFE TO DEDUCT SUCH MONIES FROM MY FUTURE CLAIMS. **I AUTHORIZE** ANY PERSON OR ORGANIZATION WITH INFORMATION CONCERNING ME, MY SPOUSE OR CO-APPLICANT AND/OR MY DEPENDENTS, 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 SERVICE PROVIDERS, FOR THE PURPOSES OF PLAN ADMINISTRATION, AUDIT AND THE ASSESSMENT, INVESTIGATION AND MANAGEMENT OF THIS CLAIM. **I AGREE** A PHOTOCOPY; FACSIMILE OR ELECTRONIC VERSION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

PRINT

SIGNATURE OF PLAN MEMBER _____

DATE (DD/MMM/YYYY) _____

PART 5 - STATEMENT OF CONFIDENTIALITY

The specific and detailed information requested on the Dental Claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer. Manulife. P.O Box 1602 Del Stn 500-4-A, Waterloo, Ontario N2J 4C6. A copy of our privacy policy is available on **manulife.ca.**

PART 6 - MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the following address:

MANULIFE CONSUMER MARKETS
DENTAL CLAIMS
PO BOX 4215, STATION A
TORONTO ON M5W 5M6

Manulife will not assume responsibility for any fees associated with the completion of this form.