Manulife Financial

Retiree Benefits Dental Claim

PART 1 - DENTIST

PATIENT

LAST NAME	GIVEN NAME	UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCT. NO.

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 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 NO. 98596

PLAN SPONSOR ENCON Group Inc. (Retiree Benefits)

NAME OF INSURANCE COMPANY **Manulife Financial**

2. YOUR NAME

YOUR CERTIFICATE NO.

YOUR DATE OF BIRTH (DD/MMM/YYYY)

BANKING INFORMATION FOR DIRECT DEPOSIT

TO HAVE THIS AND ALL FUTURE CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT, ATTACH A VOID CHEQUE TO THIS CLAIM FORM AND INDICATE "YES," IN THE BOX BELOW.

☐ YES, I HAVE ATTACHED A VOID CHEQUE AND WOULD LIKE ALL MY FUTURE CLAIMS PAYMENTS DEPOSITED INTO THIS ACCOUNT.

IF YOU HAVE SEPARATE PLAN NUMBERS FOR HEALTH AND/OR DENTAL COVERAGE UNDER YOUR MANULIFE GROUP BENEFITS PLAN, PLEASE INCLUDE THESE PLAN NUMBERS (LISTED ON YOUR WALLET IDENTIFICATION CARD) ON THE LINE BELOW.

ELECTRONIC CLAIM STATEMENTS

DID YOU KNOW THAT YOU CAN RECEIVE AN E-MAIL ALERTING YOU WHEN YOUR CLAIM HAS BEEN PROCESSED? GO TO WWW.MANULIFE.CA/GROUPBENEFITS AND CHOOSE, "PLAN MEMBER". YOU MUST BE REGISTERED TO USE THE SECURE SITE. LOG-IN AND SELECT, "ELECTRONIC CLAIM STATEMENTS" FROM THE SIDE NAVIGATION BAR.

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 NO.

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 THE INFORMATION IN THIS FORM IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND DOES NOT CONTAIN A CLAIM FOR ANY EXPENSES PREVIOUSLY PAID FOR BY ANY PLAN.

I AUTHORIZE ANY PERSON OR ORGANIZATION WHO HAS INFORMATION PERTAINING TO THIS CLAIM, INCLUDING ANY HEALTH CARE PROVIDER, INSURANCE COMPANY, ANY TYPE OF WORKERS' COMPENSATION BOARD, INVESTIGATIVE AGENCIES AND MY PLAN SPONSOR, TO RELEASE AND EXCHANGE SUCH INFORMATION REQUESTED BY MANULIFE FINANCIAL AND/OR ITS CLAIMS SERVICE PROVIDERS FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

I AUTHORIZE MANULIFE FINANCIAL AND ITS CLAIMS SERVICE PROVIDERS TO COLLECT, TO USE AND TO EXCHANGE WITH THE PERSONS OR ORGANIZATIONS LISTED ABOVE ANY INFORMATION NEEDED FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

IF THIS CLAIM IS MADE ON BEHALF OF MY SPOUSE AND/OR DEPENDENTS, I AM AUTHORIZED TO DISCLOSE INFORMATION ABOUT THEM, FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING 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 OR ELECTRONIC VERSION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

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

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 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.

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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