Manulife Financial

Group 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

PLAN SPONSOR **Toronto District School Board**

PLAN NO. **84445** DIVISION NO.

PLAN MEMBER NAME

EMPLOYEE NO.

PLAN MEMBER ADDRESS (IF DIFFERENT FROM PATIENT ADDRESS ABOVE)

CITY/TOWN PROV. POSTAL CODE

PLAN MEMBER DATE OF BIRTH (DD/MMM/YYYY)

ARE YOU, YOUR SPOUSE OR DEPENDANTS COVERED UNDER ANY OTHER PLAN FOR THE EXPENSES BEING CLAIMED?

☐ NO ☐ YES IF "YES", PLEASE PROVIDE THE FOLLOWING:

SPOUSE'S DATE OF BIRTH (DD/MMM/YYYY)

NAME OF SPOUSE'S INSURANCE COMPANY

SPOUSE'S PLAN NO.

SPOUSE'S CERTIFICATE NO.

PLEASE RETAIN PHOTOCOPIES OF ALL RECEIPTS SUBMITTED WITH THIS CLAIM FOR SUBMISSIONS TO YOUR SECONDARY CARRIER.

ARE ANY EXPENSES INCURRED AS A RESULT OF AN ACCIDENT? ☐ NO ☐ YES

IF "YES", PLEASE SPECIFY:DATE OF ACCIDENT (DD/MMM/YYYY)

DETAILS

PLEASE PROVIDE ADDITIONAL ACCIDENT DETAILS ON A SEPARATE SHEET IF INSUFFICIENT SPACE AVAILABLE.

ARE THESE EXPENSES ELIGIBLE FOR COVERAGE UNDER ANY TYPE OF WORKER'S COMPENSATION BOARD? ☐ NO ☐ YES

MANULIFE FINANCIAL'S INTERNET CAPABILITIES HAVE BEEN CHANGED - Use this link to view: (http://www.manulife.ca/groupbenefits)

PART 3 - PATIENT INFORMATION

PATIENT: RELATIONSHIP TO PLAN MEMBER

DATE OF BIRTH (DD/MMM/YYYY)

IF CHILD, INDICATE ☐ STUDENT ☐ DISABLED

IF STUDENT, INDICATE SCHOOL

IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? SEPARATELY, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

PART 4 - PLAN MEMBER CONFIRMATION

I CERTIFY THAT THE FOREGOING ANSWERS AND THE INFORMATION CONTAINED IN OTHER DOCUMENTS SUPPORTING THIS CLAIM FOR BENEFITS ARE, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, FULL AND COMPLETE. WILFUL MISREPRESENTATION COULD BE CONSIDERED FRAUD AND SUBJECT TO PENALTIES.

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

PART 5 - MAILING INSTRUCTIONS

PLEASE MAIL YOUR COMPLETED CLAIM FORM AND RECEIPTS TO THE FOLLOWING ADDRESS.

MANULIFE FINANCIAL
GROUP DENTAL CLAIMS
PO BOX 1659
WATERLOO ON N2J 4W7