Manulife Financial

Dental Care Expense
B.C. Colleges/University Colleges

Canadian Dental Association

PATIENT	DENTIST	
LAST NAME / FIRST NAME AND INITIAL	UNIQUE NO. / SPEC. / PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.
ADDRESS		
CITY / PROV. / POSTAL CODE	PHONE NO.	SIGNATURE OF EMPLOYEE

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

DUPLICATE FORM ☐

PRE-TREATMENT X-RAYS ARE REQUIRED FOR ESTIMATES/CLAIMS INVOLVING MAJOR DENTAL WORK.

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.

OFFICE VERIFICATION

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE OF SERVICE YYYY	MM	DD	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGE
						TOTAL FEE SUBMITTED		

IF YOU HAVE QUESTIONS, CALL YOUR B.C. COLLEGE'S BENEFIT HELPLINE AT 1 800 575 2200

Manulife Financial
Group Dental Claims
PO Box 2592 Station M
Calgary AB T2P 5P4

British Columbia Institute of Technology — 0083238

Plan Sponsor / Employer — Policy # — Plan Member ID #

Plan Member – Last Name — First Name and Initial — Date of Birth (yyyy/mm/dd)

Plan Member – Address — No. — Street — City — Province — Postal Code

Patient – Last Name — First Name and Initial — Relationship — Date of Birth (yyyy/mm/dd)

1. Is the dependent working? ☐ No ☐ Yes or Is the dependent attending school? ☐ No ☐ Yes
2. Are benefits available from another group plan? ☐ No ☐ Yes If yes, please provide the following information _____ (Insurance Carrier Name) _____ (Policy Number)
3. If other coverage was available and has recently terminated, please provide termination date _____ (yyyy/mm/dd)

   The spouse who is covered by another medical plan must first submit his/her claim to his/her insurer. Once that has been completed, please provide Manulife Financial with a completed claim form and a copy of the settlement provided by the other carrier. Claims for children must first be submitted to the insurer of the parent whose birthday occurs first in the calendar year.
4. If for denture, bridge, crown or onlay/inlay, is this an initial placement? ☐ No ☐ Yes

   If yes, please provide date(s) teeth were extracted and all other missing teeth in arch _____ (yyyy/mm/dd)
5. If replacement, please provide date of prior placement and reason for replacement _____ (yyyy/mm/dd) Reason _____
6. If treatment is due to an accident, indicate date of accident _____ (yyyy/mm/dd)

I authorize The Manufacturers Life Insurance Company ("Manulife Financial") to collect and exchange personal information about me and/or my dependents to process this claim and administer my group plan. I understand any personal information obtained by Manulife Financial will be kept confidential and, where necessary, Manulife Financial will be exchanging my personal information. I authorize the following persons to exchange with Manulife Financial or each other, any of my personal information in their possession: any health care practitioner, medical facility or provider of health care/dental services, any provincial health insurance plan, insurance company or reinsurer, insurance broker or plan administrator, my employer or former employer, government agency, auditing or independent investigative organization, and financial institution. I acknowledge that more detailed information concerning how and why Manulife Financial collects, uses and discloses my personal information is available at www.manulife.ca , or by requesting a copy from my plan sponsor.

I authorize the use of my Social Insurance Number for identification purposes. I certify that the information in this form is true and complete, to the best of my knowledge. A copy of this authorization shall be as valid as the original.

Signature of Plan Member (in full) — (yyyy/mm/dd)