Manulife Financial



Dental Expense Claim

D	ART	1 D	ENTICT			UNIQUE NO	SPEC	PATIENT'S OF	FICE ACCOUNT NO	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM
1 1 1	ART 1 DENTIST						TANLETT O STITLE ACCOUNTED		TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO SAME	
P A	LAST NAME GIVEN NAME					D				
T I E	A D	D	R E S	S	A P	T . E N T				
N T	CITY		PR	ΩV	POSTA	L CODE T PH	ONE NO			
	FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCI CONSIDERATION						SPECIAL	SIGNATURE OF SUBSCRIBER 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)
DUDI	IOATE E	onu F	٦					OFFICE VERIFICATION		
	ICATE F			INTL	TOOTU	DENTION				
DAY	МО	YR	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES		
									_ Membe	er - submit completed claim form to
									_	
										oloyee Benefit Plan Services Ltd., IcIntosh Drive
									- MAF	RKHAM ONTARIO
									The state of the s	8C7) 946-9700
THI	S IS AN A	CCURATE	STATEMENT OF	SERVICES	TOT	AL EEE OU	DMITTER			0-263-3564
	PERF0R	MED AND AND PAY	THIS TOTAL FEE ABLE E & OE	DUE	1017	AL FEE SU	BMILLED			
	PAF	RT 2	MEMBER		CON	IPLETE THIS E	PART BEFORE	TAKING THE EC	DRM TO YOUR	DENTIST'S OFFICE
GR				BER 9				NEFIT TRUST		DEINTIGE C CITICE
	Memb								cial Insurance Nu	mber
2.	Memb	er's da	ate of birth _	First /_		Initial	Last Employee/Certif	icate number (If ap		
			irst claim wit	Day		ear	□YES	(1	,	
	Addre									
Street City/Town Province Postal code 5. Are dental benefits payable for this claim from any other company or source? NO YES If 'Yes' name company or source										
6.	a) If de	enture,	bridge or cr	own, is	this an initia	al placement?	□NO □YE	S		
	c) If rep	olacen	nent, give d	ata of ne	ior placem	ent and reason f	or replacement.			
7.									In thin	family mambar the (sheek ene)
	Which	family	member ar	e these	expenses l	peing claimed fo	r?	Name	ls this ── □Em	family member the (check one) ployee □ Spouse □ Son □ Daughter
lf t	Which his fa	family mily	member ar	e these is a s	expenses l pouse oi	peing claimed fo	r? plete the follo	Name Dwing information	ls this □Em tion:	family member the (check one) ployee □ Spouse □ Son □ Daughter
lf t 8.	Which his fa Depen	family amily adant's	member are member date of birth	e these is a s	expenses I pouse of /_ Month	ceing claimed for child, comp	r? plete the folionis dependant w	Name Dwing informat vorking? □ NO □ N	ls this ☐Em tion: YES Is this deper	family member the (check one) ployee □ Spouse □ Son □ Daughter adant attending school? □NO □YES
If t 8.	Which his fa Depen	family amily adant's 3' give	member are member as date of birth name of em	e these is a sp n Day ployer o	expenses I pouse of //_ Month r school	ceing claimed for child, comp	r? plete the folionis dependant w	Name Dwing information or line in the li	Is this ☐Em tion: YES Is this deper	family member the (check one) ployee □ Spouse □ Son □ Daughter Indant attending school? □ NO □ YES
10. I a to ne oth pro	Which his fa Depen If 'YES If treat uthoriz process cessary ner, an ovincia ency, a	family amily adant's dant's graph ment i graph g	member and member and additional and additional and additional additional and additional additional and additional additi	e these is a s Day ployer o accident ers Lifes minister ial will I informa plan, ir dent inv	pouse of formal properties of the control of the co	ceing claimed for child, comp 9. Is the state of accident a Company ("Manuplan. I understalling my personalling my personalli	r?	Name Dwing information of collect and exchain authorize the follopractitioner, medicoroker or plan admition.	Is this Em tion: YES Is this deper ange personal infeed by Manulife Fin wing persons to eal facility or pro- ninistrator, my en	family member the (check one) ployee
If t 8. 10. I a to ne otl pro ag I a	Which his fa Depen If 'YES If treat uthoriz process cessary ner, an ovincia ency, a uthoriz	family amily adant's dant's graph of the state of the sta	member and member and additional and additional and additional and personal the insurance of or independent and additional addition	e these is a s Day ployer o accident ers Lifes minister ial will I informa plan, ir dent inv ocial Ins	pouse of formal process of the pouse of formal process of the pous	ceing claimed for child, comp 9. Is the state of accident a Company ("Manuplan. I understalling my personalling my personalli	plete the folionis dependant was and details life Financial") to and any personal information. Iny health care purer, insurance if financial institucation purposes.	Name Dwing information of collect and exchain authorize the follopractitioner, medicoroker or plan admition.	Is this Em tion: YES Is this deper ange personal infeed by Manulife Fin wing persons to eal facility or pro- ninistrator, my en	family member the (check one) ployee