

Dental Claim

To be completed by the plan member unless otherwise indicated.
Please retain copies for your files as original receipts/forms will not be returned.

1 Plan member/ Employee information

You can obtain your plan/group no., account/division no. and your certificate no. from your I.D. card.

Plan/Group no.	Acct./Div. no.	Certificate no.	Plan sponsor/Employer	
Plan member/Employee name (first, middle initial, last)			Birthdate (dd/mmm/yyyy)	
Plan member/Employee address (number, street and apt.)		City or town	Province	Postal code

Patient's name	Date of birth (dd/mmm/yyyy) (1st claim only)	Relationship to plan member (1st claim only)	Complete if patient is a student 18 or older	
			School and city	If employed, hrs worked per week

Are you, your spouse or dependents covered under any other plan for the expenses being claimed?
 Yes No If "Yes," please retain photocopies of all receipts/forms submitted with this claim for submission to your secondary carrier. If this is your first claim, or if information has changed, please provide the following:

Spouse's date of birth (dd/mmm/yyyy)	Name of spouse's insurance company	Spouse's plan/group no.	Spouse's certificate no.
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Are these expenses eligible for coverage under workers' compensation? Yes No

Are any of the services provided as the result of an accident?
 Yes No If "Yes," please explain when, where and how the injury occurred.

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Dental Accident

Orthodontic

Denture/Bridge/Crown

Is any treatment for orthodontic purposes? Yes No

If claim is for **denture, bridge or crown**, indicate if it is the initial placement or replacement and provide additional information where requested.

Initial placement	Replacement
Please give date(s) teeth were extracted for denture or bridge.	Please give date of prior placement and reason for replacement of the denture, bridge or crown.
Date (dd/mmm/yyyy)	Date (dd/mmm/yyyy) Reason

2 Claims confirmation

I certify that all goods or services being claimed have been received by me/my dependents.

I certify that the information in this form is true and complete, to the best of my knowledge. I authorize any health care provider, other insurance company, workers' compensation board, my employer, or other persons to release and exchange information requested by Manulife Financial, when the information is needed to process 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 of this authorization shall be as valid as the original.

Please sign here

Signature of plan member/employee	Date signed (dd/mmm/yyyy)
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Please see reverse



MANULIFE FINANCIAL
GROUP DENTAL CLAIMS
PO BOX 1654
WATERLOO ON N2J 4W2

◀ Please place your completed claim form in an envelope.
Peel off this mailing label and place it on your envelope.

