Manulife Financial

For your future™

Canadian Dental Association

Brick and Allied Craft Union of Canada
BAC - Canada
Employee Benefit Trust Fund - 4221

PART 1 - DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCT. NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT: LAST NAME | GIVEN NAME

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 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: $

INSTRUCTIONS

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.
ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, FLUORIDE TREATMENTS, X-RAYS, BASIC RESTORATIONS AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PREDETERMINATION OF BENEFITS.
X-RAYS MAY BE REQUESTED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIM FORMS TO:

GLOBAL BENEFITS
BRICK AND ALLIED CRAFT UNION OF CANADA
BAC - CANADA
EMPLOYEE BENEFIT TRUST FUND
88 ST. REGIS CRESCENT SOUTH
TORONTO ON M3J 1Y8
TEL: (416) 635-6000

PART 2 - PLAN MEMBER'S STATEMENT *(Complete this part before taking the form to your dentist's office)*

1. PATIENT: RELATIONSHIP TO PLAN MEMBER _____ DATE OF BIRTH _____
   IF CHILD AGE 21 OR OVER INDICATE STUDENT ☐ HANDICAPPED ☐
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOVT. AGENCY OR DENTAL PLAN? ☐ NO ☐ YES
   CONTRACT NUMBER _____
   NAME OF INSURING AGENCY _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ NO ☐ YES
   GIVE DATE AND DETAILS
4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES
5. IS YOUR DEPENDANT EMPLOYED? ☐ NO ☐ YES
   IF SO, GIVE NAME OF EMPLOYER
6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT? ☐ NO ☐ YES
7. PLAN MEMBER'S NAME: _____
   (PLEASE PRINT)
   ADDRESS: _____
   TELEPHONE NUMBER: _____
   IDENTIFICATION NUMBER: ☐☐☐-☐☐☐-☐☐☐
   DATE OF BIRTH: _____

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** Manulife Financial ("Manulife") and/or its authorized representative to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their information for the Purposes. **I authorize** any person or organization with information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with Manulife and/or its authorized representative, its reinsurers and/or its service providers, for the Purposes. **I authorize** the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that Manulife's Privacy Policy and Privacy Information Package are available at www.manulife.ca/groupbenefits, or from my plan administrator.

Plan Member's Signature: _____

Date: _____

Any information provided to or collected by Manulife and/or its authorized representative in accordance with this authorization, will be kept in a Group Benefits health file. Access to your information will be limited to:

- Manulife employees, authorized representatives, reinsurers and service providers 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, where appropriate, to have any inaccurate information corrected.

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS