

Group Benefits Dental Claim

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Please complete both pages of this form.

PART 4 - PLAN MEMBER CONFIRMATION

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. LAUTHORIZE MANULIFE FINANCIAL ("MANULIFE") 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"). LAUTHORIZED BY MY DEPENDANTS TO DISCLOSE AND RECEIVE THEIR INFORMATION, FOR THE PURPOSES. LAUTHORIZE 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, ITS REINSURERS AND/OR ITS SERVICE PROVIDERS, FOR THE PURPOSES. LAUTHORIZE 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. LAGREE A PHOTOCOPY OR ELECTRONIC VERSION OF THIS AUTHORIZATION IS VALID. LUNDERSTAND THAT MANULIFE'S PRIVACY POLICY AND PRIVACY INFORMATION PACKAGE ARE AVAILABLE AT WWW.MANULIFE.CA/GROUPBENEFITS, OR FROM MY PLAN SPONSOR.

ANY INFORMATION PROVIDED TO OR COLLECTED BY MANULIFE IN ACCORDANCE WITH THIS AUTHORIZATION, WILL BE KEPT IN A GROUP BENEFITS HEALTH FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- · MANULIFE EMPLOYEES, REPRESENTATIVES, REINSURERS, AND SERVICE PROVIDERS IN THE PERFORMANCE OF THEIR JOBS;
- PERSONS TO WHOM YOU HAVE GRANTED ACCESS; AND
- · PERSONS AUTHORIZED BY LAW.

SIGNATURE OF PLAN MEMBER

YOU HAVE THE RIGHT TO REQUEST ACCESS TO THE PERSONAL INFORMATION IN YOUR FILE, AND, WHERE APPROPRIATE, TO HAVE ANY INACCURATE INFORMATION CORRECTED.

PART 5 - MAILING INSTRUCTIONS

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

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

DATE (DD/MMM/YYYY)