U.A. LOCAL 254 HEALTH & WELFARE TRUST FUND

ADMINISTRATOR: GLOBAL BENEFITS
MANULIFE FINANCIAL - Policy Nº. 4513

CANADIAN DENTAL ASSOCIATION

PART 1 DENTIST

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

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

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.

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 CHARGES	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. E & OE

TOTAL FEE SUBMITTED

FOR ADMINISTRATOR'S USE

NOTE If treatment is required as a result of a work related accident, please file your claim with the Workplace Safety Insurance Board.

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1.
2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.

PART 2 — MEMBER

1. GROUP POLICY PLAN NO. 4513 LOCAL NO. 254 ☐ INITIAL CLAIM? SUBSEQUENTLY ☐
PRESENT EMPLOYER _____ TELEPHONE NUMBER: HOME _____ BUS. _____
2. NAME OF MEMBER _____ MEMBER'S DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____
ADDRESS OF MEMBER _____ MEMBER'S SOCIAL INSURANCE NUMBER ☐☐☐ ☐☐☐ ☐☐☐

PART 3 — PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO EMPLOYEE _____
DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____
PATIENT'S OCCUPATION _____
2. IF CLAIM IS FOR THE DEPENDENT CHILD, IS THAT CHILD
HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐
A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐
ARE YOU ENTITLED TO AN INCOME TAX EXEMPTION FOR THIS DEPENDENT? ☐ YES NO ☐
NAME AND ADDRESS OF DEPENDENT'S EMPLOYER _____
3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES? ☐ YES NO ☐ IF "YES", PROVIDE:
POLICY NUMBER: _____
NAME OF INSURER: _____
SPOUSE'S NAME: _____
SPOUSE'S DATE OF BIRTH: DAY _____ MONTH _____
4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐
5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐
B) IS IT AUTO RELATED? ☐ YES NO ☐
GIVE DATE AND DETAILS _____
C) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐
NAME OF EMPLOYER _____
6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
A) IS THIS THE INITIAL PLACEMENT?
UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐
B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT _____
C) DATE OF EXTRACTIONS _____

I authorize Global Benefits 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 obtaine by Global Benefits will be kept confidential and, where necessary, Global Benefits will be exchanging my personal information. I authorize the following persons to exchange with Global Benefits 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, or plan administrator, government agency, auditing or independent investigative organization, and financial institution. 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.

Date _____ / _____ / _____ Signature of Member _____ Telephone Number ( ) _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL (SEE OVER)