



PART 1 DENTIST		UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO SAME.
P A T I E N T	LAST NAME _____ GIVEN NAME _____	D E N T I S T			SIGNATURE OF SUBSCRIBER _____
ADDRESS _____	APT. _____				
CITY _____ PROV. _____	POSTAL CODE _____				
		PHONE NUMBER _____			

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION. DUPLICATE FORM <input type="checkbox"/>	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) _____
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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 THIS TOTAL FEE DUE AND PAYABLE E & OE	TOTAL FEE SUBMITTED
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IF CHARGES WILL BE \$500 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 REQUIRED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIMS FORMS TO:
IUPAT BENEFIT TRUST ADMINISTRATION
P. O. BOX 1280, STATION B
MISSISSAUGA, ON L4Y 3W5

PART 2 MEMBER'S STATEMENT COMPLETE THIS PART BEFORE TAKING THE FORM TO YOUR DENTIST'S OFFICE

1. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH _____
 IF CHILD, INDICATE FULL TIME STUDENT HANDICAPPED
 DATE ENROLLED _____ DATE COMPLETED _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOV'T AGENCY OR DENTAL PLAN?
 NO YES POLICY NUMBER _____
 NAME OF INSURING AGENCY _____
 IF CLAIM IS FOR A DEPENDANT CHILD PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

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. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO YES
 IF INITIAL PLACEMENT ADVISE DATE TEETH WERE EXTRACTED _____
 AND ALL OTHER MISSING TEETH IN ARCH _____
 IF REPLACEMENT GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. _____

6. IS TREATMENT RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY, OR OTHERWISE RELATED TO EMPLOYMENT?
 NO YES

7. INITIAL CLAIM? SUBSEQUENT?

8. MEMBER'S IDENTIFICATION NUMBER [] [] [] [] - [] [] [] [] - [] [] [] []

9. DATE OF BIRTH _____
 MEMBER'S NAME (PLEASE PRINT) _____
 ADDRESS _____
 IS THIS A CHANGE OF ADDRESS FROM YOUR LAST CLAIM SUBMISSION? NO YES
 IF YES, PLEASE ADVISE EFFECTIVE DATE OF CHANGE (MM/DD/YY) _____
PLEASE NOTE ALL FUTURE IUPAT BENEFIT TRUST CORRESPONDENCE WILL BE DIRECTED TO THE ABOVE ADDRESS.
 TELEPHONE NUMBER _____
 COMPANY NAME _____
 LOCAL NUMBER _____ DATE _____ / _____ / _____
DAY MONTH YEAR

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.