Manulife Financial

INTERNATIONAL UNION OF PAINTERS AND ALLIED TRADES WELFARE FUND DENTAL EXPENSE CLAIM SF-6122

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.

SIGNATURE OF SUBSCRIBER

PATIENT
LAST NAME GIVEN NAME
ADDRESS APT.
CITY PROV. POSTAL CODE

DENTIST
PHONE NUMBER

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 THIS TOTAL FEE DUE AND PAYABLE E & OE

TOTAL FEE SUBMITTED

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-RAY'S, 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.

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS