Manulife Financial

Group Benefits
Dental Benefit Cost Plus Claim - Signature

- *Separate claim forms are required for Extended Health Care and Dental Benefit Cost Plus claims.*
- *Attach a completed Dental Benefit Claim form and applicable receipts or a copy of your original dental claim statement with this form.*
- *Manulife Financial will first determine if your claim is eligible under your Dental Benefit before considering a claim under your Cost Plus Benefit.*
- ***Note:** Depending on the situation, Cost Plus may not be tax-effective. For example, special tax rules apply to owners and shareholder-managers. Consult your tax advisor for additional information.*
- *Manulife Financial will only consider dental expenses eligible under the Income Tax Act and where permitted by law.*
- *Your Cost Plus Benefit is provided directly by your plan sponsor and is not insured by Manulife Financial.*

1 Plan member information

Plan contract number	Plan member certificate number	Plan sponsor

Plan member name (first, middle initial, last)	Birthdate (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City	Province	Postal code

*If you or your dependants have dental coverage under another plan, the claim should be submitted to that plan **before** using Cost Plus.*

2 Claims information

Total amount of ALL receipts submitted	$

3 Plan sponsor signature

To certify plan member/dependant eligibility for the Cost Plus Benefit, the plan sponsor must sign and date this form.

Signature of plan sponsor	Date signed (dd/mmm/yyyy)

4 Plan member's authorization

ORIGINAL RECEIPTS must be attached for all expenses.

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") 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, 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 Sponsor.

Please sign here

Signature of plan member	Date signed (dd/mmm/yyyy)

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.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

5 Mailing instructions

Please mail your completed claim form(s) and applicable receipts to the appropriate address:

If you live outside Quebec:
Manulife Financial Group Benefits
Dental Claims
PO BOX 1654
WATERLOO ON N2J 4W2

If you live in Quebec:
Manulife Financial Group Benefits
Dental Claims
P.O. BOX 5000, STATION B
MONTREAL QC H3B 4B5