



**PART 4 - PLAN MEMBER CONFIRMATION**

I CERTIFY THAT THE INFORMATION IN THIS FORM IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND DOES NOT CONTAIN A CLAIM FOR ANY EXPENSES PREVIOUSLY PAID FOR BY ANY PLAN.

I AUTHORIZE ANY PERSON OR ORGANIZATION WHO HAS INFORMATION PERTAINING TO THIS CLAIM, INCLUDING ANY HEALTH CARE PROVIDER, INSURANCE COMPANY, ANY TYPE OF WORKERS' COMPENSATION BOARD, INVESTIGATIVE AGENCIES AND MY PLAN SPONSOR, TO RELEASE AND EXCHANGE SUCH INFORMATION REQUESTED BY MANULIFE FINANCIAL AND/OR ITS CLAIMS SERVICE PROVIDERS FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

I AUTHORIZE MANULIFE FINANCIAL AND ITS CLAIMS SERVICE PROVIDERS TO COLLECT, TO USE AND TO EXCHANGE WITH THE PERSONS OR ORGANIZATIONS LISTED ABOVE ANY INFORMATION NEEDED FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

IF THIS CLAIM IS MADE ON BEHALF OF MY SPOUSE AND/OR DEPENDENTS, I AM AUTHORIZED TO DISCLOSE INFORMATION ABOUT THEM, FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

IF MY SOCIAL INSURANCE NUMBER IS USED AS MY CERTIFICATE NUMBER, I AUTHORIZE ITS USE FOR THE IDENTIFICATION AND ADMINISTRATION OF MY GROUP BENEFITS.

I AGREE THAT A PHOTOCOPY OR ELECTRONIC VERSION OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

**SIGNATURE OF PLAN MEMBER**

**DATE (DD/MMM/YYYY)**

AT MANULIFE FINANCIAL, WE KNOW THAT CONFIDENTIALITY OF PERSONAL INFORMATION IS IMPORTANT. ANY INFORMATION YOU PROVIDE TO US WILL BE KEPT IN A GROUP LIFE AND HEALTH BENEFITS FILE. ACCESS TO YOUR INFORMATION WILL BE LIMITED TO:

- OUR EMPLOYEES AND SERVICE REPRESENTATIVES 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, IF NECESSARY, CORRECT ANY INACCURATE INFORMATION.

**PART 5 - MAILING INSTRUCTIONS**

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

**IF YOU LIVE OUTSIDE** MANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMS  
**OF QUEBEC:** P.O. BOX 1654, WATERLOO ON N2J 4W2

**IF YOU LIVE** MANULIFE FINANCIAL GROUP BENEFITS DENTAL CLAIMS  
**IN QUEBEC:** P.O. BOX 5000, STATION B, MONTREAL QC H3B 4B5