MANITOBA BLUE CROSS®

UNIVERSITY OF MANITOBA
RETIRED STAFF DENTAL PLAN
DENTAL CLAIM FORM

MAIL TO: MANITOBA BLUE CROSS
P.O. BOX 1046, WINNIPEG, R3C 2X7

DATE RECEIVED

DENTIST

DENTIST NO.

DENTIST NAME

DENTIST ADDRESS

CITY/PROVINCE

POSTAL CODE

SERVICES FOR BENEFITS HAVE BEEN

❑ PERFORMED ❑ PLANNED

PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS $500.00 OR MORE.

COVERAGE

Full-Time Member

Basic Services 80%
Major Services 60%

Orthodontic Services 50%

FOR DEPENDENT CHILDREN ONLY, TO THEIR 19TH BIRTHDAY, PROVIDED THAT BRACES WERE PLACED PRIOR TO THEIR 18TH BIRTHDAY.

Part-Time Member

Basic Services 50%
Major Services 50%

Orthodontic Services 50%

FOR DEPENDENT CHILDREN ONLY, TO THEIR 19TH BIRTHDAY, PROVIDED THAT BRACES WERE PLACED PRIOR TO THEIR 18TH BIRTHDAY.

ELIGIBLE DEPENDENTS

THE RETIRED MEMBER'S **SPOUSE** AND ANY **UNMARRIED CHILD** WHO **NORMALLY RESIDE** WITH THE RETIRED MEMBER AT HIS/HER REGULAR RESIDENCE IN THE PROVINCE OF MANITOBA.

SPOUSE – THE RETIRED MEMBER'S LEGAL SPOUSE, COMMON-LAW SPOUSE OR SAME-SEX PARTNER (COMMON-LAW SPOUSE OR SAME-SEX PARTNER MEANS THE INDIVIDUAL WHO HAS BEEN RESIDING WITH THE RETIRED MEMBER IN A CONJUGAL RELATIONSHIP FOR A PERIOD OF NOT LESS THAN ONE YEAR.)

CHILD – ANY UNMARRIED NATURAL CHILD, ADOPTED CHILD, OR STEP-CHILD OF THE RETIRED MEMBER AND INCLUDES ANY CHILD FOR WHOM THE RETIRED MEMBER HAS BEEN APPOINTED LEGAL GUARDIAN BY A COURT OF COMPETENT JURISDICTION PROVIDED SATISFACTORY PROOF OF SUCH GUARDIANSHIP IS PROVIDED TO THE INSURER:

i) FROM BIRTH BUT UNDER 18 YEARS OF AGE;

ii) UP TO 25 YEARS OF AGE IF A FULL-TIME STUDENT AT A SCHOOL, COLLEGE OR UNIVERSITY;

iii) OVER 18 YEARS OF AGE, BUT CONTINUES TO BE INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF MENTAL OR PHYSICAL HANDICAP,

AND CHIEFLY DEPENDENT ON THE RETIRED MEMBER FOR SUPPORT AND MAINTENANCE.

RETIRED MEMBER

RETIRED MEMBER INFORMATION — COMPLETE IN FULL

Refer to your Manitoba Blue Cross ID Card

CERTIFICATE NUMBER

CLIENT NUMBER **7426**

SURNAME

FIRST NAME

ADDRESS

CITY, PROVINCE

POSTAL CODE

HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? ❑ YES ❑ NO

PHONE HOME

OFFICE

SERVICE RECIPIENT INFORMATION MUST BE GIVEN
SERVICE RECIPIENT'S FIRST NAME

BIRTH DATE MON. YEAR

RELATIONSHIP TO RETIRED MEMBER
❑ SELF ❑ SPOUSE ❑ DEPENDENT

IF CHILD OVER AGE 18, INDICATE SCHOOL ATTENDED

IS TREATMENT REQUIRED AS A RESULT OF ACCIDENT?

❑ YES ❑ NO IF YES, GIVE DETAILS

ARE DENTAL BENEFITS PROVIDED UNDER ANY OTHER INSURANCE OR DENTAL PLAN?

❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING

PERSON INSURED UNDER OTHER PLAN

EMPL OYER

EMPLOYER'S INSURANCE COMPANY

POLICY OR CERTIFICATE NUMBER

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MANITOBA BLUE CROSS. I CERTIFY THAT I AM A RETIRED MEMBER OF THE UNIVERSITY OF MANITOBA AND THAT THE SERVICES OUTLINED HEREIN ARE FOR MYSELF, OR MY ELIGIBLE DEPENDENT. I ALSO CERTIFY THAT I AM AN ELIGIBLE RETIRED MEMBER OF THE UNIVERSITY OF MANITOBA RETIRED MEMBER DENTAL PLAN, AND THAT THE INFORMATION CONTAINED IN THIS FORM IS COMPLETE AND ACCURATE.

IS PAYMENT TO BE MADE TO DENTIST/DENTURIST? ❑ YES ❑ NO

SIGNATURE OF ELIGIBLE RETIRED MEMBER

3 - DENTIST — Examination and Treatment Record

BLUE CROSS USE ONLY

SERVICES PERFOR. DAY	MON.	YR.	TOOTH CODE INT.NO.	PROCEDURE NUMBER	SPECIFIC SURFACES FILLED	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS PAYS	REJECT REASON
								$	$	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE SERVICE RECIPIENT NAMED.

DENTIST'S SIGNATURE _____ DATE: _____

NOTE: • RETIRED MEMBER SECTIONS TO BE COMPLETED BY RETIRED MEMBER AND MUST BE SIGNED.
• DENTIST SECTION TO BE COMPLETED BY DENTIST.

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Manitoba Blue Cross's privacy policies I can contact Manitoba Blue Cross at 204.775.0151 or at www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Manitoba Blue Cross to collect, use and disclose my personal information as described above.