



**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 AND INVESTIGATIVE AGENCIES 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 DEPENDANTS, I AM AUTHORIZED TO DISCLOSE INFORMATION ABOUT THEM, FOR THE PURPOSE OF PLAN ADMINISTRATION INCLUDING PROCESSING AND INVESTIGATING THIS CLAIM.

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)**

**PART 5 - STATEMENT OF CONFIDENTIALITY**

The specific and detailed information requested on the Dental Claim form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife Financial) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife Financial employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife Financial at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer, Manulife, P.O Box 1602 Del Stn 500-4-A, Waterloo, Ontario N2J 4C6. A copy of our privacy principles and practices is available for view at [manulife.ca](http://manulife.ca).

**PART 6 - MAILING INSTRUCTIONS**

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

MANULIFE FINANCIAL AFFINITY MARKETS  
DENTAL CLAIMS  
PO BOX 4215, STATION A  
TORONTO ON M5W 5M6

Visit [manulife.ca/affinityforms](http://manulife.ca/affinityforms) to print out additional copies of the Dental Claim Form

Manulife Financial will not assume responsibility for any fees associated with the completion of this form.