



DATE RECEIVED

D E N T I S T	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%		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.		FOR DEPENDENT CHILDREN ONLY, TO THEIR 19TH BIRTHDAY, PROVIDED THAT BRACES WERE PLACED PRIOR TO THEIR 18TH BIRTHDAY.								
	ELIGIBLE DEPENDENTS										
	THE RETIRED MEMBER'S <u>SPOUSE</u> AND ANY <u>UNMARRIED CHILD</u> 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.										
3 - DENTIST Examination and Treatment Record										BLUE CROSS USE ONLY	
SERVICES PERFOR.			TOOTH CODE	PROCEDURE	SPECIFIC SURFACES	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS PAYS	REJECT REASON	
DAY	MON.	YR.	INT.NO.	NUMBER	FILLED						
I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE SERVICE RECIPIENT NAMED.									\$		
DENTIST'S SIGNATURE _____									DATE: _____		
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								BIRTH DATE		RELATIONSHIP TO RETIRED MEMBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
SERVICE RECIPIENT'S FIRST NAME _____								MON.	YEAR		
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 _____											

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†Blue Shield is a registered trade-mark of the Blue Cross Blue Shield Association.



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.