# UNIVERSITY OF MANITOBA RETIRED STAFF DENTAL PLAN DENTAL CLAIM FORM

## Retired Member Information — Complete in Full

- **Certificate Number**: [Insert Certificate Number]
- **Client Number**: 7426
- **Surname**: [Insert Surname]
- **First Name**: [Insert First Name]
- **Address**: [Insert Address]
- **City, Province**: [Insert City, Province]
- **Postal Code**: [Insert Postal Code]
- **Birth Date**: [Insert Birth Date]
- **Relationship to Retired Member**: [Insert Relationship]

## Service Recipient Information Must Be Given

- **Service Recipient’s First Name**: [Insert First Name]
- **First Name**: [Insert First Name]
- **Relationship to Retired Member**: [Insert Relationship]

## 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**: [Insert Spouse Information]
  - **Unmarried Child**: [Insert Unmarried Child Information]

## 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%

## Are Dental Benefits Provided Under Any Other Insurance or Dental Plan?

- **Yes**: [Insert Yes/No]

## Person Insured Under Other Plan

- **Employer**: [Insert Employer]
- **Employer’s Insurance Company**: [Insert Insurance Company]
- **Policy or Certificate Number**: [Insert Policy or Certificate Number]

## Signature of Eligible Retired Member

- [Insert Signature]

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**3 - Dentist**

<table>
<thead>
<tr>
<th>Service Performed Code</th>
<th>Procedure Number</th>
<th>Specific Surfaces Filled</th>
<th>Service Material</th>
<th>Qty or Units</th>
<th>Amount Billed</th>
<th>Blue Cross Pays</th>
<th>Reject Reason</th>
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**I hereby certify that the services listed above are correct and represent those rendered to the service recipient named.**

- **Dentist’s Signature**: [Insert Signature]
- **Date**: [Insert Date]

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**Note**: • Retired Member Sections to be Completed by Retired Member and Must Be Signed.

• Dentist Section to be Completed by Dentist.

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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.