



STANDARD DENTAL CLAIM FORM

| PA | V™ RT 1 | DENTI | ST | | | | | | | | | IQUE N | | | | | PEC. | | PAT | TIENT | S OFFICE ACCOU | JNT NO. | | | | ABLE FROM THIS CLAUS |
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| P A T I E N | FIRST NA | | | | | | | | | NAME PT. | D E N T I S | 2 | | Ke | enne | eva | ale | | | uit | e 204 | | | | | |
| T | CITY | | | | P | ROV. | | | POST | AL CODE | T | | PHONI | E NO. | (61 | 3) 4 | 440 |)-611 | 6 | | | | | SIGNATURI | F OF SURS | CRIRER |
| FOR | DENTIST | USE ONL | Y - F0 | R ADI | DITION | IAL INF | FORMA | TION, I | DIAGNO | ISIS, PROCEDU | RES,O | R SPEC | IAL CO | INSIDE | ERATIO | INS. | | BENEF I ACKI SERVI I AUTH PLAN | FITS. I U NOWLE CES RE HORIZE ADMINI RVICES | JNDEI DGE 1 ENDEF RELE ISTRA DESC | RSTAND THAT I / THAT THE TOTAL RED. ASE OF THE INFO TOR. I ALSO AUT RIBED IN THIS F | AM FINANCI FEE OF \$ DRMATION O THORIZE THI FORM TO TH | ALLY RESPONSIE IS CONTAINED IN THE E COMMUNICATIO E NAMED DENTIS | OT BE COVERE BLE TO MY DEI ACCURATE AI IS CLAIM FORM OF INFORM ST. | ED BY OR I NTIST FOR ND HAS BI M TO MY II ATION REL | MAY EXCEED MY PLAN THE ENTIRE TREATMENT. EEN CHARGED TO ME FOR ISURING COMPANY / ATED TO THE COVERAGE |
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| | | CCURATE AL FEE D | | | | | | RFORM | ED | TOTA | \L F | EE S | UBN | /IIT1 | ΓED | | | | | | | OLA | NO. | | | |
| IN | STRUC | TIONS | F0 | R CL | LAIN | I SU | BMIS | SSIO | N | | | | | | | | | | | | | | | | | |
| YO | JR CERTI | FICATE OF | RFROI | N YOU | JR EMI | PL0YE | R. | | | | | | | | | | | | | | | | | N DETAILS FRO | OM EITHEF | YOUR PLAN BOOKLET, |
| | | | | | | | | | | | | | | | | | | | | | ARRIER'S APPR WHO WILL COM | | LAIMS OFFICE. T 4 AND FORWAF | RD THE FORM | TO THE C | RRIER. |
| | | EMPL | | | LAN | MEN | /IBEF | R/SU | | | | | | | | | | | | | | | | | | |
| 1. 6 | ROUP PO | LICY/PLA | N NO. | | | | | | DI | VISION/SECTIO | N NO | | | | | | | OUR NAM | - | | | | | | | |
| EM | PLOYER _ | | | | | | | | | | | | | | | | | | | | . OR I.D. NO | | | | | |
| NAI | ME OF INS | SURING A | GENC | OR F | PLAN_ | | | | | | | | | | | | YOU | JR DATE (|)F BIRT | Н | DAY MO | ONTH YE | AR | | | |
| | | PATIE | | | | | N | | | | | | | | | | | | | | | | | | | |
| 1. F | | LAN MEM | | | | | | | | | | | | | | | | | | | QUIRED AS THE D DETAILS SEPE | | F AN ACCIDENT? | □ NO | | YES |
| | D | ATE OF BI | RTH_ | DAY | N | IONTH | Y | EAR | IF CHII | LD INDICATE: 🗆 | STUI | DENT [| HAN | DICAF | PPED | | | | | | OR BRIDGE, IS T PLACEMENT AND | | PLACEMENT? OR REPLACEMENT | NT. NO | | YES |
| | II | STUDEN | T, IND | ICATE | SCH0 | 0L | | | | | | | | | | | 5. 1 | S ANY TR | EATME | NT RE | EQUIRED FOR OF | RTHODONTI | C PURPOSES? | □ NO | | YES |
| 2. A | | | | | | | | | | IY OTHER GROU | | | | | | | T | THE INSU | RER / P | LAN / | | AND CERT | | | | OF THIS CLAIM TO Rue, Correct and |
| | | .B. OR GO | | | | | _ | YES | | | | ,,,,,,,, | 022 | - | | | | , o | | | | | | DATE _ | | |
| | | | | | | | | | | OF BIRTH | | | | | | | | | | | | | | | DAY (| MONTH (YEAR) |
| | | | | | | | | | | | | | | | | | | | | | OYEE/PLAN MEI | VIBER/SUBS | CRIBER | | | |
| PA | RT 4. | - POLI | CY H | IOL | DER/ | | | | | COMPLET | ON | ONL | IF P | APPI | LICA | BLE | . SE | | VE*) | | | | | | | |
| 1. [| ATE COV | ERAGE CO | MME | NCED | | DAY | | MON | TH | YEAR | 4 | CONTR | ACT H | OLDEF | , [| T | T | DATE | | | | | АЦІТН | ORIZED SIGNA | TURE | |
| 2. [| ATE DEP | ENDENT C | | | | | | | | | • | | | 1 | | DAY | | MONTH | YEA | R | | | | | | |
| 3. [| ATE TER | MINATED | | | L | | | | | | | | | | | | | | | | | | (P0 | SITION OR TIT | LE) | |



Standard Dental Claim

| | CTI | | 1· D | ENTIST | Γ INFORM <i>A</i> | ATION | | | | | | | |
|------------------|------------------|--------------|--------------|-------------------|------------------------------------|---|---|----------|---------------------------------|------------------------------|------------------------------------|--|---|
| | Last N | | | <u>-INTIOT</u> | INFORMA | Given N | lame | | Unique No. | | Spec | | Patient's Office Acct. No. |
| A - | Addre | SS | | | | | Apt. | | D E N | | | | |
| 1 | City | | | | Prov | ·. | Postal | al Code | T I S T Phone No | 0. | | | |
| | Dentis | | | | ditional inform | uation, diagn | nosis, procedure | es, or | I hereby assi | ign my bene ayment direct | efits payable f ctly to him/her | | im to the named Doublet and |
| | | | | | | | | | Lunderstand | d that the fe | s. I understan | | not be covered by or may financially responsible to my |
| | | | | | | | | | charged to r | me for servion this claim f | form to my ins | | is accurate and has been release of the information any/plan administrator. |
| | | | | | | | | | (PARENT/G | BUARDIAN |) | | NORMAN AND AND AND AND AND AND AND AND AND A |
| | ouplica of Se | | | rocedure | Intl. Tooth | Tooth | | | Office verific | ation & | CHARLE D.M.D., MS | S COHEN S.D., F.R.C.D. | (C) |
| DAY | _ | YR. | ⊣ " | Code | Code | Surfaces | Dentist's Fe | ee | Charge | Total C | harges | | HECK HERE IF REATMENT PLAN |
| | | | | | of services pe | O COE | DES TOTAL FEE | SUBMIT | ITED: \$ | | | is expect a treatme OTIP Ber advised o your plan Pre-treati some pro | proposed course of treatment ted to cost more than \$500, ent plan must be filed with nefits Services. You will be of the benefits payable under a before treatment begins. The ment x-rays are required for occodures (e.g. crowns and |
| | | | | | able, E & OE. | | | | | | | bridges). | |
| | | | | | | | L INFORM | ATIO | N | | | | |
| | | | | | iddle Initial and | | | | Data of Birth | //dd/nn | - A | | |
| | | | ition in | Number | Plan Nu | umber | | | Date of Birth | | /y) | | |
| Pla | n Spo | nsor | | | | | | t | Email Address | 1 | | | |
| Re Vis nav | it www igatio | your ow.otip | claim po.com | and log in | n. Once you ha | ave logged i I tion. First-ti | and enjoy the on to the Plan Milme users, you | 1ember | Secure Site (a | also known a | as 'My Claims | | My profile from the top |
| | | | | | | | | [| Date of Birth (r. | nm/dd/yyyy | () | | |
| lf | Child, | , india | cate: | □ St | tudent 🗆 Ha | andicapped | | If | f Student, Indi | cate Schoo | l | | |
| | | | | | services provide ensation board | | y other group in nent plan? | nsuranc | ce or dental pla | an? □ Yes | s □ No | | |
| P | lan Co | ontrad | ct Nur | nber | | | | ! | Name of Insur | ance Comp | oany | | |
| S | pouse |) Date | e of Bi | irth <i>(mm/c</i> | dd/yyyy) | | | | | | | | |
| | | | | | | | ? If " Yes ", give | | | | | | |
| | | | | | • | | Give date of prid | or place | ment and reas | son for repla | acement. | Yes □ No | |
| 5. ls | any t | .reatm | nent re | equired for | or orthodontic p | ourposes? | ☐ Yes ☐ No | | | | | | |

DENTAL 09/20 Page 1 of 2

SECTION 4: CERTIFICATION AND AUTHORIZATION

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. I authorize OTIP and the group benefits insurance carrier ("Insurer") that provides my benefits coverage to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). I am authorized by my Dependants to disclose and receive their Information, for the Purposes. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.nanulife.com, or by request.

Date (mm/dd/yyyy)

| Signature of Plan Member | | |
|--------------------------|--|--|

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file.

Access to your Information will be limited to:

- ♦ The Insurer and their reinsurers and service providers 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, where appropriate, to have any inaccurate information corrected.

SECTION 5: MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

OTIP Dental Claims

PO Box 280

Waterloo ON N2J 4A7

QUESTIONS?

OTIP Benefits Services 1-866-783-6847

DENTAL 09/20 Page 2 of 2



STANDARD DENTAL CLAIM FORM

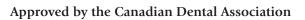




| | U | | | | | Please | e prii | nt | | | | | - | W _M | |
|--------------------------------|--------------|-----------|-----------|---------------|------------|--------------|--------|--------|------------------------|-------------|---------------|------------|---------|--|--|
| PART 1 DEN | NTIST | | | | | | | 695 | JE NO. 07250 | | PEC. Ortho | | PATIE | NT'S OFFICE ACCOUNT NO. | I HEREBY ASSIGN MY BENEFIT PAYABLE FROM THIS CLAIM TO THE |
| P LAST NAME | | | | | | GIVEN NA | AME | E [| Or. Cha | arles | Cohe | en - | | | NAMED DENTIST AND A THORIZE PAYMENT DIRECTLY TO THE DENTIST |
| A ADDRESS | | | | | | A | DT | N 2 | | | | | | ite 204 | |
| E | | | PROV | , | | POSTAL CO | | į ľ | Nepear | n, ON | K2 | J 6E | 36 | | |
| N CITY | | | | | | | | | HONE NO | | | | | | SIGNATURE OF SUBSCRIBER |
| FOR DENTIST'S PROCEDURES, (| | | | | ORMATIO | N, DIAGNOS | - 1 | PLAN | BENEFIT | | | | | | BE COVERED BY OR MAY EXCEED MY SIBLE TO MY DENTIST FOR THE ENTIRE |
| | | | | | | | | I ACK | TMENT. NOWLED | GE THA | T THE | E TO1 | AL FEE | E OF \$ | IS ACCURATE AND HAS BEEN |
| | | | | | | | - 1 | CHAR | IGED IO | IVIE FOR | SER | VICE | 2 HEINL | JERED. | THIS CLAIM FORM TO MY INSURING |
| | | | | | | | | COMF | PANY/PLA | N ADM | INISTI | RATO | R. I AL | | UNICATION OF INFORMATION RELATED |
| | | | | | | | | | ATURE O | | | | | | HE NAMED DENTIST. |
| DUPLICATE FOR | RM \square | | | | | | | OFFIC | E VERIF | CATIO | | ₽ 0 | HARLE | S COHEN E.D., F.R.C.D.(C) | |
| DATE OF SERVICE DAY MO. YR. | | CEDUF | | TOOTH TOO | | DENTIST'S | | LABO | DRATORY | , | | | RGES | INI | STRUCTIONS |
| DAY MO. YH. | | ODE | | ODE SURFA | CES | FEE | | | HARGE | | Т | П | | All claims under this grou | up benefits plan are submitted through may exchange personal information |
| | | | | | | | | + | ++ | ++ | | | + | about claims with the | plan member and a person acting ecessary to confirm eligibility and to |
| | | | | | | | | + | | | + | | + | mutually manage the cla | ims. |
| | | | | | | | | | | ++ | | | + | Have your dentist con Employee completes | Parts 2 and 3. |
| | | | | | | | | + | ++ | ++ | + | | + | assignment portion of | be paid directly to the dentist, sign the Part 1 above. Assignment of benefits |
| | | | | \exists NO | CO | DES | Н | + | | + | | | | is irrevocable. Canada with the assignee. | a Life may discuss details of this claim |
| | | | | | | | Ы | + | | + | + | | | 4. Send this claim to: | |
| | | | | | | | | + | ++ | ++ | + | | + | | Toll Free: 1-800-957-9777 |
| | | | | | | | | + | | | + | | | Winnipeg Benefit Payn PO Box 3050 Station N | |
| | | | | | | | | + | + | ++ | + | | | Winnipeg MB R3C 0E6 | 3 |
| | | | | | | | | | | ++ | + | | | www.canadalife.com | hearing and require access |
| THIS IS AN ACCU | RATE S | TATEM | FNT OF SI | ERVICES PERI | OBMED | | | | | | | | | to a telecommu | inications relay service? us: TTY to Voice: 711 |
| AND THE TOTAL | FEE DU | E AND | PAYABLE, | E. & O.E. | OTTIVILED | TOTAL F | EE S | SUBI | MITTE |) | | | | Voice to TTY: 1- | 800-855-0511 |
| PART 2 EM | | | | | | | | | | | | | | | |
| Plan Numbe | r | | | | | Division N | luml | ber_ | | | | | _ Em | nployee Identification N | umber |
| Plan Name | | | | | | | | | | | | | | | |
| Employee Na | ame _ | | | | | | | | | | | | | Date | of birth/// Day Month Year |
| Employee ac | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | r the purposes of assessing your our personal information policies |
| and practices | s (incli | uding | with res | spect to ser | vice pro | oviders), w | /rite | to Ca | anada L | ife's (| Chief | Cor | nplian | nce Officer or refer to w | ww.canadalife.com. |
| I also conser | nt to th | ne use | of my p | personal inf | ormatic | on for Car | nada | ı Life | and its | affilia | tes' i | nteri | nal da | ta management and ar | nalytics purposes. |
| I authorize (| Canad | a Life | e, anv h | ealthcare r | orovide | r, my plan | adı | minis | strator. | other | insur | anc | e or r | einsurance companies | s, administrators of government |
| benefits or o | ther b | enefit | s progra | ams, other | organiz | ations, or | serv | rice p | provide | s wor | king | with | Cana | ada Life, located within | or outside Canada, to exchange |
| | | | | | | | | | | | | | | | disclosure to those authorized best of my knowledge. |
| | | | | | | - | | | | • | | | | • | te |
| , , | | | | | | | | | | | | | | Du | |
| PART 3 CO | ORDIN | OITA | N OF B | ENEFITS | | | | | | | | | | | |
| | | | | | | | | | | | | | | 2. Patient's date of | |
| 3. If the pati | ient is | a chil | d, does | the patient | reside | with you? | | Yes | ☐ No | | | | | | Day Month Year |
| 4. If the child | d is ov | /er 18 | : a) Is | the depend | ent a fu | ıll-time stu | ıden | t? | Yes | No | | | | | |
| | | | | student, hov | | | | | | | | | | | |
| | | | c) Is t | the depend | ent emp | oloyed? | Ye | s | No | f yes, | how | mai | ny hou | urs worked per week? - | |
| 5. a) Are yo | | | | | | | | | | | | | | | |
| If yes, | , name | e of fa | mily me | ember insur | ed | | | | | | | | Rela | tionship to employee _ | |
| | | | | | | | | | | | | | | | |
| b) Is any | / mem | ber of | f your fa | mily (other | than yo | ourself) ins | sure | d as | an emp | loyee | unde | er th | is plar | n? 🗌 Yes 🔲 No | |
| c) If yes | to que | estion | s 5 a) o | r b), and th | e patier | nt is a dep | end | ent c | hild, ple | ease p | rovic | le sp | oouse | 's Date of Birth/_ | |
| 6. Is this tre | atmen | ıt requ | uired as | the result of | of an ac | cident? | Ye | s [| No | | | | | Day | Month Year |
| If yes, giv | e date | e, loca | ation, an | nd explain h | ow acc | ident happ | oene | ed | | | | | | | |
| 7. Is a claim | n being | g mad | e for W | orker's Con | npensat | tion Benef | its? | | Yes | \square N | 0 | | | | |
| 8. If claim is | for de | enture | , crown | or bridge, | is this ir | nitial place | mer | nt? | Yes | \square N | o If | no, (| give d | ate of prior placement | and reason for replacement. |
| | | | | | | | | | | | | | | | |

Dental Claim Form







| | 10 De | complet | ea by L | entist | | | | | | | | | | | | | |
|--------|---------------------------|--|---|--|------------------------------|--------------------|---------------------------------------|-----------------------------------|---|--|---|---|-----------------------------------|------------------------------|---|---|----------------------------------|
| P A | Last Nam | ie | | Giver | Name | 69 | ique Number 9507250 | | Spec. Ortho | Patient's C | Office | Account | No. | | from th | assign my ber is claim to the horize paymer | named deplist |
| T - | Address | | | | Apt. | D E N T | | neva | ale D | rive, Suite | 204 | | | | him/he | | it directly to |
| N | City | | Prov. | Posta | l Code | I S | Nepean, | ON | K2J | 080 | | | | | | | |
| Т | | | | | | T | Phone No. | (61 | 13) 44 | 10-6116 | | | | | | Signature of S | iubscriber |
| spec | Dentist's Uial conside | | lditional inf | ormation, diag | nosis, pr | ocedures, o | or | ben I ac serv con cov | efits. I knowle vices re npany / rerage con nature c | understand the dge that the t ndered. I auth | at I am otal fe orize r trator. cribed ent/G | n financia ee of \$ elease o I also au in this fo uardian) | f the inf ithorize orm to t | formati the co the nan | e to my dent s accurate a on in this cl mmunicatio | aim form to m n of informati | re treatment. arged to me for |
| Date o | f Service | Procedure | Intl | Tooth | | Dentist's | Lab | orator | | | | | | | | | Jse Only |
| | onth Year | Code | Tooth Code | Surfaces | | Fee | C | harge ['] | | Total Charg | es | | or P | tan <i>I</i> | Admini | strator | ose Only |
| T | | ccurate stateme d and the total payable E & O | ent of service fee due and | | | S FEE SUBI | MITTED | | | | | | | | | | |
| 2 | Infor | mation ab | out vo | u – he sure | to ful | llv comp | lete this se | ectio | n | | | | | | | | |
| Cont | ract numb | | | ID number | | | sponsor/em | | | | | | | | Proforma | Hanguago of c | orrespondence |
| - | | | | | | . ou. piu. | . spenser, em | ,,,,,, | | | | | | | | sh 🗆 French | on espendence |
| Your | last name | | | | First n | ame | | | | | □ N | Male emale | Date | of birth | ı (yyyy-mm- | dd) Daytime | phone number — |
| Your | address (s | treet number ar | nd name) | | | Apa | rtment or su | ite | City | | | | | F | Province | Postal co | de |
| 3 | Spou | se and chi | ildren c | overed b | y thi | s claim | ı – comple | ete ti | his sed | ction if clai | m is f | or spo | use or | child | | · | |
| Spou | se's last n | ame | | | | First na | ame | | | | | | | Date o | of birth (yyy) | /-mm-dd) | ☐ Male ☐ Female |
| Child | 's name | | | | | | onship to you | | Date | of birth (yyyy- | -mm-d | 1 . | nplete f age limi | its) | rage depend | • | penefit information |
| 4 | Co-o | rdination | of bene | efits – cor | nplete | this sect | ion <u>if your</u> | spo | use <u>ar</u> | nd/or chil <u>d</u> | ren h | as cov | erage | unde <u>r</u> | any othe | er dental pla | ın or contract |
| If yes | ur spot s,: • \ • \ | ise or are yo You must su You must su Yalendar yea Ise's plan is | our child bmit a c bmit a c r. | ren covere laim for yo laim for yo | d for a our spo our ch | any of thouse to i | nese exper his/her pl under the | nses an f | unde irst. | r any othe | er dei | ntal pl | an or | conti | ract? | No □ | Yes |
| | ract numb | | | ember ID num | | | | date | of birth | n (yyyy-mm-do | d) | Do you | | | ordinate be | nefits (process | both claims)? |
| | , spouse's | signature | | | | | | | | | | | | | | Date (yyyy-mn | n-dd) |
| X | | | | | | | | | | | | | | | 1 | | |

Page **1** of 2 DENT-E-08-17 For SLF use: DCF

5 Details of claim If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist). 1. Are any expenses the result of an accident? \square No \square Yes If yes, complete the following: When did the accident occur? (yyyy-mm-dd) Where did the accident occur? How did the accident occur? ☐ Work ☐ Home ☐ Other Are any expenses the result of a condition covered by a workers' compensation program? ☐ No ☐ Yes ☐ No ☐ Yes 2. Is this treatment for orthodontic purposes? ☐ No Implants? 3. Crowns, Bridges, Dentures Is this the initial placement? ☐ Yes If No, date of prior placement (yyyy-mm-dd) Reason for replacement If Yes, date teeth were extracted (for denture or bridge) (yyyy-mm-dd) Please include the following to facilitate handling of your claim: • Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays) List of all missing teeth (for bridges only)

6 Authorization and signature - you must complete this section

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada ("Sun Life") to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

| Member's signature | Date (yyyy-mm-dd) |
|--------------------|-------------------|
| X | |

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit www.sunlife.ca/privacy.

Questions? Please visit www.sunlife.ca or call our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – keep a copy of your claim form and receipts for your records

Mail your completed form to the claims office nearest you.

Sun Life Assurance Company of Canada PO Box 11658 Stn CV Montreal OC H3C 6C1 Sun Life Assurance Company of Canada PO Box 2010 Stn Waterloo Waterloo ON N2J 0A6

For SLF use: DCF



Group Benefits Dental Claim

| PART 1 - DENTIST | | | | |
|---|----------------------|--|---|---|
| P LAST NAME | GIVEN NAME | UNIQUE NO. 69507250 | SPEC. Ortho | PATIENT'S OFFICE ACCT. NO. |
| T ADDRESS I E N CITY PROV. | APT. POSTAL CODE | D Dr. Charles Cohe E 240 Kennevale D T Nepean, ON K2J S PHONE NO. (613) 44 | rive, Suite 204 6B6 | |
| FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFO | DRMATION, DIAGNOSIS, | 1 | S PAYABLE FROM THIS CLAIM TO | O THE NAMED DENTIST AND |
| PROCEDURES, OR SPECIAL CONSIDERATION. | | SIGNATURE OF PLAN MEMBER | | |
| | | MY PLAN BENEFITS. I UNDERS ENTIRE TREATMENT. | STAND THAT I AM FINANCIALLY F | OT BE COVERED BY OR MAY EXCEED RESPONSIBLE TO MY DENTIST FOR THE IS ACCURATE AND HAS ZE RELEASE OF THE INFORMATION |
| | | CONTAINED IN THIS CLAIM FO | RM TO MY INSURING COMPANY. | ZE RELEASE OF THE INFORMATION /PLAN ADMINISTRATOR. |
| DUPLICATE FORM | | (PARENT/GUARDIAN) OFFICE VERIFICATION | CHARLES COH | EN C.D.(C) |
| DATE OF SERVICE DAY MO. YR. PROCEDURE CODE TOOTH CODE | TOOTH DENTIST'S FEE | LABORATORY TOTAL C | CHARGES | CK HERE IF TREATMENT PLAN |
| NO | CODES | | WHEN A I TREATME THAN \$5 FILED WI' YOU WILL PAYABLE BEFORE | PROPOSED COURSE OF NT IS EXPECTED TO COST MORE 00, A TREATMENT PLAN MUST BE TH MANULIFE GROUP BENEFITS. L BE ADVISED OF THE BENEFITS UNDER THE GROUP PLAN TREATMENT BEGINS. |
| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORM THE TOTAL FEE DUE AND PAYABLE, E & OE. PART 2 - PLAN MEMBER INFORMAT | IOTAL FEE SUBMIT | TTED: \$ | FOR SOM | ATMENT X-RAYS ARE REQUIRED E PROCEDURES (E.G. CROWNS, ES, BRIDGES, AND IMPLANTS). |
| 1. PLAN CONTRACT NUMBER | | 2. PLAN MEMBER NAME (PL | EASE PRINT) | |
| PLAN SPONSOR | | PLAN MEMBER CERTIFICA | ATE NUMBER | |
| NAME OF INSURANCE COMPANY | Manulife | | | |
| | | DAYTIME PHONE NUMBE | R | |
| PART 3 - PATIENT INFORMATION 1. PATIENT: RELATIONSHIP TO PLAN MEMBER DATE OF BIRTH (DD/MMM/YYYY) | | ELIGIBLE FOR WORKERS | COMPENSATION BENEFITS? | RK RELATED INCIDENT AND NO YES CIAL WORKERS COMPENSATION |
| IF CHILD, INDICATE STUDENT IF STUDENT, INDICATE SCHOOL | HANDICAPPED | 3. IS ANY TREATMENT REQU ACCIDENT? IF YES, GIVE DATE AND D | | NO YES |
| 2. ARE ANY DENTAL BENEFITS OR SERVICES PROV INSURANCE, DENTAL OR GOV'T PLAN? SPOUSE DATE OF BIRTH (DD/MMM/YYYY) NAME OF INSURANCE COMPANY | NO YES | IS THIS THE INITIAL PLAC | LIST ALL MISSING TEETH. EMENT? OR PLACEMENT AND REASO | □ NO □ YES |
| IF MANULIFE, PLAN CONTRACT NUMBER | | 5. IS ANY TREATMENT REQU PURPOSES? | IIRED FOR ORTHODONTIC | ☐ NO ☐ YES |

Please complete both pages of this form.

PART 4 - BANKING INFORMATION AND EMAIL ADDRESS

Visit **manulife.ca/planmember** to register and sign in to your Plan Member secure site. Then sign up for direct deposit and electronic claim statements under the My Profile menu OR complete this section.

By providing your banking information, your claim payments will be deposited directly to your account. Locate your banking information on your personal cheque or bank statement, or contact your branch.

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| Transit nun | nber Ins | titution numbe | r Account numbe | r | |
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Complete **only** when providing new or updated information.

By providing your email address, you will receive an email notification once your claim has been processed, including a link to **manulife.ca**, where you can sign in to view your electronic claim statements. To ensure you can view your electronic claim statements online and your paper claim statements are discontinued, visit **manulife.ca/planmember** to register for your Plan Member secure site.

| Email | ad | dres | ss (| Plea | ase | pri | nt c | lea | rly) | | | | | | | | | | | | |
|-------|----|------|------|------|-----|-----|------|-----|------|--|--|--|--|--|--|--|--|--|--|--|--|
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PART 5 - AUTHORIZATION AND CONSENT

By submitting a claim to Manulife, I confirm that I understand and agree to all of the following:

I certify that the information provided for the claim(s) being submitted is true, accurate and complete and that I, my spouse and/or my dependants have received all goods or services as claimed. I understand and acknowledge that submission of a claim determined by Manulife to be false or misrepresented will be reported, together with any related information/documentation, to my plan sponsor. I understand and acknowledge that Manulife may refer any claims it has determined were falsely submitted to law enforcement authorities for possible prosecution. Manulife will pursue the recovery of any money that has been obtained improperly through false claim submission. I authorize any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with Manulife, its reinsurers and/or its service providers, for the purposes of Group Benefits plan administration, audit and the assessment, investigation and management of this claim (Purposes). I agree that my coverage may be denied or terminated because of my providing false, incomplete or misleading Information.

<u>l agree</u> to refund any monies or overpayments that I may owe to Manulife in accordance with the provisions of the Group Benefits plan with Manulife, and <u>l authorize</u> Manulife to deduct such monies from my future claims. <u>l authorize</u> the use of my Social Insurance Number ("SIN") for the purposes of identification and administration, if my SIN is used as my plan member certificate number. <u>l agree</u> a photocopy, facsimile or electronic version of this authorization shall be as valid as the original. <u>l understand</u> that Manulife's Privacy Policy is available at manulife.ca/groupbenefits, or from my Plan Sponsor.

If applicable, <u>I authorize</u> Manulife to deposit all payments due to me from the above-referenced Group Benefits Plan ("Payments") into the bank account ("Account") that I have identified on this form. <u>I confirm</u> that this direct bank deposit authorization applies to the financial institution herein named by me and any other financial institution I choose to name in the future and shall remain valid until revoked in writing by me or by my duly authorized representative.

I understand and agree that upon the deposit of any Payment(s) into the Account, Manulife is fully discharged from any further liability with respect to such Payment(s). I also understand and agree that Manulife may, at any time and without prior notice, discontinue the direct deposit of Payment(s) requested herein and require my personal written endorsement relating to future Payment(s). I also hereby acknowledge and agree that any Payment(s) made by Manulife into the Account to which I am not entitled, either by contract or by law, shall not form part of my property and shall be immediately refunded to Manulife, either by me, by my duly authorized representatives or by representatives of my estate.

If applicable, <u>I authorize</u> Manulife to use the email address provided as a means of communication with me related to my group benefits. <u>I agree</u> that Manulife is not liable for damages which I may incur as a result of interception by a third party of an email transmission sent by Manulife or by me pursuant to this authorization. <u>I agree</u> that should the email address identified on this form change, I am responsible for updating the email address maintained by Manulife. <u>I understand</u> that if I do not wish to receive emails from Manulife, I can unsubscribe, remove my email address online or contact the Customer Service Centre at 1-800-268-6195 to have my email address removed.

<u>I understand</u> that any Information provided to or collected by Manulife in accordance with this authorization, will be kept in a Group Benefits health file. Access to my Information will be limited to:

- Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs;
- persons to whom I have granted access; and
- persons authorized by law.

<u>I have the right</u> to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

PLEASE SIGN HERE

Signature of plan member ______ Date signed (dd/mmm/yyyy)_

PART 6 - MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the appropriate address.

If you live outside Quebec: Manulife Group Benefits Dental Claims PO BOX 1654 WATERLOO ON N2J 4W2 If you live in Quebec: Manulife Group Benefits Dental Claims PO BOX 5000, STN B MONTREAL QC H3B 4B5

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STANDARD DENTAL CLAIM FORM

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STANDARD DENTAL CLAIM FORM



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