

DATE RECEIVED

DENTIST / DENTURIST	DENTIST/DENTURIST NO.	DENTIST/DENTURIST NAME		EMPLOYEE		CONTRACT NUMBER		GROUP NUMBER			
	ADDRESS				SURNAME	FIRST NAME					
	CITY/PROVINCE				POSTAL CODE			BIRTH DATE			
								DAY	MON.	YEAR	
	SERVICES FOR BENEFITS HAVE BEEN				POSTAL CODE						
PATIENT	PERFORMED PLANNED PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS \$500.00 OR MORE.				HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? YES NO						
	IS TREATMENT REQUIRED AS A RESULT OF ACCIDENT? YES NO IF YES, GIVE DETAILS 				PATIENT INFORMATION MUST BE GIVEN PATIENT'S FIRST NAME		BIRTH DATE		RELATIONSHIP TO EMPLOYEE 1 SELF 2 SPOUSE 3 DEPENDENT		
							DAY	MON.			YEAR
EMPLOYEE					PHONE		HOME		OFFICE		
	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. IS PAYMENT TO BE MADE TO THE DENTIST/DENTURIST? YES NO										
	ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR DENTAL PLAN? YES NO IF YES, COMPLETE THE FOLLOWING PERSON INSURED UNDER OTHER PLAN BIRTH DATE DAY / MONTH / YEAR EMPLOYER EMPLOYER'S INSURANCE COMPANY POLICY OR CONTRACT NUMBER				SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) _____ PLEASE SIGN HERE						

IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

1. AGE OF THE CHILD		
2. IS HE/SHE MARRIED	YES	NO
3. IS HE/SHE EMPLOYED FULL TIME	YES	NO
4. IS HE/SHE IN FULL TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY	YES	NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT	YES	NO

[illegible]

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 Blue Cross' privacy policies I can contact Blue Cross at 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 Blue Cross to collect, use and disclose my personal information as described above.