P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7
PHONE TOLL FREE WITHIN MANITOBA AT 1-800-USE-BLUE (1-800-873-2583)

FEES FOR THE COMPLETION OF THIS FORM ARE NOT ELIGIBLE.

EXTENDED HEALTH BENEFITS CLAIM FORM

For Dental Accident Only

GROUP	BLUE CROSS CONTRACT NO.	SURNAME	PATIENT FIRST NAME	BIRTH YEAR

HAS YOUR ADDRESS CHANGED IN PAST YEAR ❑ YES ❑ NO	STREET, P.O. BOX NO.	CITY/TOWN	VILLAGE	POSTAL CODE

ACCIDENT DATE: ______

ACCIDENT LOCATION: ______

COMPLETE ACCIDENT DETAILS: ______

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE?

DENTAL PLAN ❑ YES ❑ NO

HEALTH PLAN ❑ YES ❑ NO

IF YES, COMPLETE THE FOLLOWING:

PERSON INSURED UNDER OTHER PLAN: ______

EMPLOYER: ______

EMPLOYER'S INSURANCE CO.: ______

POLICY OR CONTRACT NUMBER: ______

REPORT OF ATTENDING DENTIST

DENTIST

DATE PATIENT FIRST TREATED FOR INJURIES RESULTING FROM THIS ACCIDENT: ______ DATE OF LAST TREATMENT: ______

DESCRIBE EXACT NATURE, LOCATION AND EXTENT OF ALL INJURIES SUSTAINED: ______

DATE: ______ , 20 ______

DENTIST SIGNATURE: ______ DATE: ______ , 20 ______

NAME AND ADDRESS OF DENTAL OFFICE:

NAME: ______

ADDRESS: ______

DENTIST REPORT

PRE-TREATMENT AUTHORIZATION IS REQUIRED ON DENTAL WORK IN EXCESS OF $500.00

HAS TREATMENT BEEN COMPLETED? ❑ YES ❑ NO PLEASE COMPLETE FUTURE TREATMENT BELOW.

DENTIST

SERVICES PERFORMED DAY	MON.	YR.	TOOTH CODE	PROCEDURE NUMBER	AMOUNT	BLUE CROSS ONLY M.D.A.	AMOUNT
				TOTAL			

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S SIGNATURE ______ DATE: ______

FUTURE TREATMENT – PLEASE INDICATE ANY FUTURE WORK WHICH MAY BE REQUIRED AS A RESULT OF THIS ACCIDENT.

TOOTH	PROCEDURE	YEAR SERVICE TO BE PERFORMED	CURRENT COST (APPROX.)	REMARKS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?

❑ YES ❑ NO

I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER:

NAME ______

ADDRESS ______

______ POSTAL CODE ______

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 THE ABOVE PROVIDER FOR THE ENTIRE COST OF THE TREATMENT.

SUBSCRIBER'S SIGNATURE ______
(PLEASE SIGN HERE)

PHONE RES: ______ BUS.: ______

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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 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.